Medicaid Program Evaluation

Working Paper

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

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MPE 4.3 February, 1987

UTAH'S CHOICE OF HEALTH CARE DELIVERY PROGRAM: IMPLEMENTING PRIMARY CARE CASE MANAGEMENT IN MEDICAID

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This Working Paper was developed under HCFA Contract No. 500-83-0058, by James Bell Associates, Inc., Suite 826, 1700 North Moore Street, Arlington, Virginia 22209, (703) 528-3230

Suggested citation format:

Rosenthal, Helen, Larry Beyna and James Bell, Utah's Choice of Health Care Delivery Program: Implementing Primary Care Case Management in Medicaid, Medicaid Program Evaluation Working Paper 4.3, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, February, 1987.

PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the states much more flexibility to change basic parameters of the program, including which groups of people are served, what services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation (MPE) addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and policy questions raised by recent legislation:

- Federal Financial Participation
- Inpatient Hospital Reimbursement
- Eligibility
- Case Management
- Home and Community-Based Waiver Program
- Cost-Sharing
- Financial Incentives for Family Care
- Medicare DRG Effects on Medicaid and
- Synthesis.

Together these studies are intended to describe how recent changes have been implemented, and analyze what their effects have been for program services and costs.

This paper provides a detailed description of the Utah Choice of Health Care Delivery program (CHCD), one of the early Medicaid case management programs initiated under OBRA-authorized waivers of the freedom-of-choice requirement. It covers the CHCD's first three years of planning and implementation, including details about the program's design, involvement of providers and recipients, administration, and early impact on the accessibility, quality and costs of care

under Medicaid.

This description of Utah's CHCD is modeled after the description of Michigan's Primary Physician Sponsor Plan, which is provided in MPE Working Paper 4.2. Michigan's and Utah's programs were the first two of six studied under Task 4 of the MPE. The other four case studies (Kansas, Colorado, Nevada and Wisconsin) were briefer but followed the same basic format. Reports of those case studies are presented in Working Paper 4.4. A synthesis of findings from all six case studies is available in Working Paper 4.5, and a statistical analysis of claims data to assess the impact of the Utah program is provided in Working Paper 4.6.

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ACKNOWLEDGEMENTS

We are indebted to many Utah officials for their help in this study of the Choice of Health Care Delivery program. For their very valuable insights into the origin, design, operation and effectiveness of the program, we particularly thank: Sharon Wasek, former Director, and Robert G. Ogden, current Director, Division of Health Care Financing, Utah Department of Health; Ed Furia, Director of the Bureau of Managed Health Care, Division of Health Care Financing, Dr. Roger Suchyta, liaison with the Utah State Medical Association from Utah's Medicaid Office; Bill Walsh, Director, Utah Issues; officials of FHP, the first HMO involved in the program; and many Medicaid providers in the four Wasatch Front counties.

We are especially grateful to Carol Thomas, DHCF's CHCD Program Coordinator, whose enthusiasm for the CHCD and patience with our probing and requests for information made our job much easier than it might have been.

Finally, thanks go to Rowena Gear, who was responsible for word processing and other report preparation tasks.

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CONTENTS

ACRONYMS USED IN THIS REPORT

AFDC	Aid to Familes with Dependent Children program
CHCD	Choice of Health Care Delivery Program
DHCF	Division of Health Care Financing (Utah Department of Health)
DHHS	U.S. Department of Health and Human Services
FFS	Fee-for-Service
FHP	Family Health Plan, a local HMO
HCFA	Health Care Financing Administration, DHSS
HMO	Health Maintenance Organization
HPR	Health Program Representative
IPA	Independent Practice Assocation
NCQA	National Committee on Quality Assurance
SSI	Supplemental Security Income Program
SURS	Surveillance and Utilization Review System
USMA	Utah State Medical Association

EXECUTIVE SUMMARY

In early 1981, the Omnibus Budget Reconciliation Act gave state Medicaid agencies a major boost in the development of primary care case management programs (PCCMs). Among other things, the Act allowed the Health Care Financing Administration to facilitate PCCM implementation by waiving the requirement that states guarantee freedom-of-choice of provider for all Medicaid recipients. This new flexibility encouraged the Utah Department of Health's Division of Health Care Financing (DHCF) to explore PCCM as a strategy for controlling Medicaid utilization, containing costs, and increasing access and care continuity -- all of which were very pressing needs in the late 1970's and early 1980's.

Encouraged by the success of its limited lock-in program for over-utilizers and its small HMO program for Medicaid recipients, DHCF saw PCCM, under a freedom-of-choice waiver, as a means of both expanding the use of case management as a general Medicaid service delivery strategy and increasing the enrollment of Medicaid recipients in HMOs. The result was the Choice of Health Care Delivery program (CHCD).

DESIGN AND DEVELOPMENT OF THE CHCD

Under the CHCD, most AFDC and SSI Medicaid recipients would be required to choose between enrolling with an individual physician or with an HMO as their primary care case manager. Several small groups of recipients were not to be included in the CHCD: residents of long-term care facilities, lock-in program participants, general assistance recipients, individuals in protective custody, foster care children, and short-term Medicaid eligibles. Enrollees would be required to remain with their chosen case managers for 12 months. (This was later changed to allow a change of provider once a month.)

Physician and HMO case managers would be responsible for virtually all Medicaid services. Case managers would be expected to provide the majority of health care to their enrollees, prior authorize other care, complete a written form for all referrals to specialist physician care, ensure 24-hour-a-day

coverage for enrollees, and instruct enrollees in how to proceed in emergency situations.

Any primary care or specialist physician could serve as a case manager, but it was expected that few specialists would do so. Since the CHCD would be mandatory for recipients, any primary care physician who wanted to serve Medicaid patients had to do so through the CHCD. Individual physician participation in the CHCD would require no official agreement or contract beyond the customary agreement between physicians and DHCF regarding participation in the Medicaid program generally. Physicians merely would have to indicate their interest in becoming case managers, and then perform their role as expected.

Individual physician case managers would be reimbursed under the usual fee-for-service (FFS) approach, while HMOs would be pre-paid a monthly capitated rate and assume risk for each recipient they case managed. Unlike the PCCM programs in several other states, the CHCD would not pay a monthly case management fee. DHCF considered a fee unnecessary, since physicians would be performing very few additional tasks as case managers.

In addition to its usual Medicaid responsibilities, DHCF would provide each individual case manager physician with a quarterly list of his/her CHCD enrollees and, upon request, a detailed list of all bills paid for any particular enrollee. Outside of the required referral forms, the CHCD would involve no special monitoring of physicians' service patterns. However, at about the same time as CHCD implementation, DHCF installed a new surveillance and utilization review system (SURS), which would identify recipients and providers with exceptionally high utilization levels.

With these basic features, the CHCD was expected to accomplish three major objectives: (1) to provide recipients access to mainstream medical care, that is, to increase the number of physicians participating in Medicaid and establish a constructive, continuous patient-doctor relationship for every recipient; (2) to better manage recipients' use of medical services, that is, to use the case manager as "gatekeeper" for all services, to reduce the number of different physicians seen by individual recipients, and to reduce the inappropriate use of services; and (3) to contain costs in Medicaid while paying equitable fees to

physicians, that is, to reduce expenditures for unnecessary or inappropriate services.

DHCF's design for the CHCD received a generally positive response from Utah Issues (the state's leading welfare advocacy group), the Utah State Medical Association, and one of the two HMOs that were expected to participate. Utah Issues saw the CHCD as a means of assuring all Medicaid recipients access to a regular primary care provider. Although physicians would have preferred to receive additional compensation for case management, they saw the program as having little actual impact on their practice of medicine; and they welcomed it as a way of reducing recipients' inappropriate use of emergency rooms and other medical services. The Family Health Plan, a staff HMO that had been active in Medicaid for several years, welcomed the CHCD as a source of additional Medicaid enrollees. HMO Utah, an IPA type HMO eventually decided not to participate because Medicaid clients were considered too great a financial risk. DHCF staff believe that they were able to obtain widespread support for the CHCD because they included the various parties in the actual design of the program, they took major responsibility for the time-consuming staff work involved, and they had the full support of the Director of the Utah Department of Health, who was well respected in the public health community.

Before applying for a freedom-of-choice waiver, DHCF conducted a pilot test of the CHCD in Weber County (near Salt Lake City). A waiver was not needed for the pilot test since recipients were allowed to remain in the standard FFS program if they did not want to enroll in an HMO or under a CHCD physician. Marketing of Weber County physicians began in November, 1981, and enrollment of recipients in December. Both groups responded very positively to the program. One important lesson learned from the pilot was that public assistance caseworkers were not committed enough to the success of CHCD to act effectively as recipient information and enrollment agents. They were soon relieved of CHCD responsibilities and DHCF hired Health Program Representatives (HPRs) to take their place.

Soon after the pilot began, DHCF applied for a freedom-of-choice waiver and a waiver allowing the state to act as a "central broker" to help recipients choose their case managers. A two-year waiver was approved in March, 1982 (and

renewed two years later). With waiver approval, DHCF proceeded to implement CHCD on a mandatory basis in the four most populous counties in the state, the Wasatch Front counties of Salt Lake, Weber, Davis and Utah. These counties contained about 80 percent of all Medicaid recipients in Utah, and were the only part of the state served by HMOs. Although DHCF intended to implement the CHCD statewide, expansion into the rural counties was postponed for several years, primarily because of the absence of HMOs.

IMPLEMENTATION

Recruiting Primary Care Physicians

An estimated 75 percent of Utah's primary care physicians did not participate in the Medicaid program before the introduction of the CHCD. Low reimbursement rates, inaccurate and slow reimbursement procedures, a sufficient supply of private patients, and the difficulty of managing Medicaid recipients were all cited as reasons for low participation. While the CHCD would have no direct impact on the first three reasons, it did offer the prospect of more constructive patient-doctor relationships. Another incentive for physicians to join the CHCD was the possibility that, at some time in the future, Utah would use CHCD savings to increase reimbursement rates. Of course, for those physicians who were already in Medicaid, the most important incentive to join the CHCD was the fact that it was the only way they could retain their Medicaid caseloads.

With endorsements from the medical community, DHCF began marketing the CHCD with a mass mailing to all Medicaid-enrolled primary care physicians in May, 1982. Only 30 percent of the targeted physicians responded. This low response was not a serious problem, however. Very few Medicaid and non-Medicaid physicians actually refused to join the program when later asked by a locally based HPR on behalf of enrollees who had specifically requested them as case managers. Many case managers were recruited through this personal, case-by-case approach. Although this use of HPRs was very labor intensive, and therefore costly, it proved very effective in the long run--not just for recruiting physicians but also for enrolling recipients, troubleshooting, providing information, and so on.

In mid-1986, CHCD officials expressed the belief that the program had increased the number of primary care physicians participating in Medicaid, but there were no pre-CHCD data to allow an accurate assessment. It was clear that the number of primary care physicians in CHCD had increased during the early implementation years, to over 1,000 in mid-1986, but it is not known how many of these physicians were new to the Medicaid program and had joined because of the CHCD.

Enrolling Medicaid Recipients

As of July, 1983, about 50,500 of the 58,000 Medicaid recipients in Utah were eligible for the CHCD. They accounted for approximately $64 million, or 52 percent, of Medicaid's non-long-term-care expenditures in FY 1983. Ninety percent of those eligibles were AFDC recipients. Eighty percent of them lived in the four Wasatch Front counties.

From the start, DHCF made it clear to recipients that CHCD enrollment was mandatory. Eight (now ten) HPRs, who worked on-site at local public assistance offices, helped recipients choose an HMO or an individual case manager at the time of public assistance eligibility certification or redetermination.

By mid-1983, after one year of implementation, 15,500 recipients had enrolled in the CHCD--31 percent of the total targeted for the state and 41 percent of the four-county eligibles. Two and one-half years later, enrollment had increased to 34,700, about two-thirds of the state target and nearly all of the Wasatch Front eligibles.

During these early years, one of every five enrollees chose HMO membership. As more HMOs have become involved in Medicaid (a total of four in late 1986), however, the proportion of enrollees choosing HMOs has increased. To date, very few HMO enrollees have changed from HMOs to individual case manager physicians. At one point the estimate was about 0.8 percent per month.

Administering CHCD

During SFYs 1984-86, the annual cost of administering the CHCD increased from $287,000 to $394,000, primarily because of the expansion of the state- and local-level staffs. By far, staff costs were the largest CHCD expense, about 90 percent of the total each year. Other expenses included space, supplies and equipment.

Utah's use of specially designated, locally-based staff, the HPRs, to handle physician and enrollee affairs was, perhaps, the most unusual and effective administrative feature of the CHCD. Although they were costly, their efficiency was greatly enhanced by their use of personal computers for entering and retrieving data on physicians and enrollees, another innovative feature. According to DHCF, the CHCD's heavy reliance on personal rapport between HPRs and enrollees and between HPRs and case managers minimized the need for systematic monitoring of compliance with case management procedures.

PRELIMINARY PROGRESS TOWARD CHCD OBJECTIVES

After over four years of CHCD implementation, DHCF officials believed that the program had increased Medicaid recipients' access to mainstream medical care by increasing the number of Medicaid primary care physicians and by establishing many patient-doctor relationships where none had existed before. Aside from testimonials from several quarters, there were no data to confirm or deny this claim, however.

As for better management of recipients' use of medical services, early pre-post data from Salt Lake County suggest that the CHCD helped reduce utilization--presumably inappropriate utilization--among non-HMO enrollees. There were substantial reductions in the numbers of physician office visits, emergency room claims, pharmacy claims and different physicians seen by recipients.

Early data from Salt Lake County also suggest that the CHCD was responsible for a reduction in Medicaid service expenditures. It was estimated that the

program saved about $423,200, or $32 per enrollee, in the county during SFY 1982-83. If generalized to the entire four-county CHCD enrollment, and if adjusted for CHCD administrative costs, these savings amount to $1.3 million.

Utah recently reported the results of a comparison group analysis of SFY 1984 and 1985 Medicaid expenditure data for CHCD enrollees and FFS recipients. After administrative costs are taken into account, it appears that both the individual case management and the HMO components of the CHCD saved money over the standard FFS system. Based on enrollment estimates for 1985, it is estimated that Medicaid saved about $99,000 through the HMO component and about $933,000 through case management during that year. Within those components, the results varied, however. The CHCD actually lost money on AFDC recipients and medically needy children in HMOs and on aged recipients in case management.

Assuming increased CHCD enrollment throughout the state and increased HMO enrollment, DHCF estimated that the CHCD would save $3.9 million in SFY 1986 (7 percent less than would be spent under FFS), and $6.3 million in SFY 1987 (10.4 percent less than under FFS).

DHCF's findings that case management reduces utilization and expenditures were not corroborated by a recent econometric analysis of December, 1983, claims data for comparable case managed and non-case managed recipients. That analysis, which is still being reviewed and was limited in several important respects, suggested that utilization was generally higher and expenditures for services were about one-fourth higher under case management. Unfortunately, the analysis focused only on one month of primary care case management experience and was limited to recipients who were continuously eligible for Medicaid for several months before and after the analysis month. Furthermore, since the CHCD was still relatively new in December, 1983, it stands to reason that utilization under case management might be high during the initial period. Many physicians and enrollees were entering a new relationship, which may very well have involved more than the usual number of office visits and baseline diagnostic procedures.

CONCLUSION

Compared to other states' PCCM programs, Utah's CHCD was simply designed and smoothly implemented. It gave providers enhanced ability to manage care because each Medicaid enrollee selected an individual physician or HMO as their primary source of care. It also promoted HMO development and offered increased access and continuity of care to recipients. For these reasons--and because it was a mandatory program--it was accepted by the Medicaid community. In addition, the individual attention provided by local CHCD personnel, the Health Program Representatives, appears to have been a major factor in the relatively successful recruitment of physicians and enrollment of recipients, and in the on-going maintenance of the program.

The CHCD is perceived by Utah officials as having improved recipient access to Medicaid services. The data available to DHCF also suggest that both the case management and the HMO components of the program reduce utilization and Medicaid service expenditures. (As of this writing, DHCF is reviewing the findings from the December 1983 claims analysis.) As a result, Utah Medicaid officials have remained committed to expanding the CHCD statewide and increasing HMO involvement in the program.

CHAPTER 1
BACKGROUND OF THE UTAH CHOICE OF HEALTH CARE DELIVERY PROGRAM

1.1 IMPETUS FOR THE PROGRAM

By early 1981, the Utah Department of Health realized that there were three serious problems with Medicaid primary care. First, too many Medicaid recipients were unable or unwilling to find a single doctor who would take principal responsibility for their care. As a result, many Medicaid recipients were relying on hospital emergency rooms or multiple physicians for their medical care. For example, Utah statistics indicated that over 50 percent of Medicaid recipients were using three or more physicians.

Second, this lack of an established relationship with a primary care physician meant that recipients were not using medical services in the best possible manner. Duplicate services were common, recipients were using costly specialists when a primary physician was more appropriate, continuity of care was not being maintained, and recipient education about important topics such as preventive care was being neglected. In short, the quality of care was not as good as it could be, and providers were becoming disillusioned about the Medicaid program and its recipients.

Third, and partly as a result of these first two problems, Utah's health care costs were rising rapidly. In 1970, total hospital expenditures in Utah were $79.3 million or $74.33 per capita. By 1981, total hospital expenditures increased to $431.3 million or $283.77 per capita. Expenditures for physician services were also increasing rapidly. From 1976-80, physician expenditures in Utah, including both Medicaid and all other payers, grew 16.7 percent per year.

These rates of increase placed enormous pressures on third party payers in Utah. One commercial insurer filed for bankruptcy and most others were

seriously concerned about their ability to pay claims without further increasing premiums. At the same time, many large insurers were dropping out of the health insurance market. The situation was so alarming that the State Insurance Commissioner began requiring regulated health insurance carriers to file monthly financial statements in order to help protect the public against future bankruptcies.

From Utah's perspective, it was fortunate that the Omnibus Budget Reconciliation Act of 1981 made it possible for individual states to apply for a freedom of choice waiver in order to exercise greater flexibility in solving Medicaid problems. Among other changes, this national legislation allowed states to assign each Medicaid recipient to one provider who serves as a gatekeeper to medical services. This "primary care physician" is responsible for ensuring that each recipient receives high quality care, as economically as possible.

A freedom of choice waiver also allowed states to encourage or direct patients into capitated service systems, such as staff-model and IPA-model health maintenance organizations (HMOs). The Utah Department of Health wanted to expand Medicaid HMO enrollment and saw the waiver as a major vehicle for doing so. Recognizing the potential value of this change as a means of addressing quality and cost concerns simultaneously, Utah was one of the first states to request a waiver and receive approval to implement these restrictions on recipient freedom of choice.

1.2 DEVELOPING THE CONCEPT

Utah's plan was developed internally by the Department of Health, Division of Health Care Financing (DHCF). In May, 1981, the Director of DHCF began to explore the possibility of restricting Medicaid recipients to one medical provider. Utah had already had some experience with its successful lock-in program for health care abusers. In the lock-in program, which was established in 1976, abusing recipients are assigned to primary physicians, who then make all referrals to specialists and pharmacies. While the lock-in program has been very successful in altering recipient behavior and controlling abuses and costs,

it has covered only a small number of recipients -- under 150 in 1980, for example.

After reviewing federal regulations and studying related proposals in Massachusetts and Michigan, DHCF designed Utah's Choice of Health Care Delivery model (CHCD). As with the lock-in program, the design of CHCD required the primary physician or an HMO to be the direct provider or gatekeeper for all services; but, unlike the lock-in program, CHCD was applicable to most, not merely a few, non-institutional Medicaid recipients, and it allowed recipients to choose their own providers. These providers could be recipients' current physicians, if registered to serve under Medicaid and willing to serve as case managers, or one of three other possible providers:

(1) any other primary care physicians in Utah who were willing to accept Medicaid recipients as patients and abide by the rules of the the case management program;

(2) FHP, a staff-model Health Maintenance Organization (HMO) under contract to Medicaid with coverage in Salt Lake City and Ogden; and

(3) HMO Utah, an IPA-type HMO sponsored by Blue Cross/Blue Shield of Utah.

In short, the CHCD provided recipients with a choice of enrolling with an individual physician, who was reimbursed on a fee-for-service basis, or enrolling in an HMO, which was reimbursed on a capitated basis.

FHP's participation in the Medicaid program preceded implementation of CHCD. In this respect, Utah was one of only a handful of states offering an HMO/fee-for-service choice to recipients in the early 1980s. Utah's goal ever since has been to increase the number of Medicaid recipients receiving services on a capitated basis.

Primary care physicians participating in CHCD were reimbursed according to the standard Medicaid fee-for-service rates and were not paid an additional case management fee. FHP and HMO Utah were reimbursed a negotiated amount on a prepaid, capitated risk basis. CHCD comprehensively covered all medically prescribed treatments, including primary and specialty care, hospitalization, prescriptions, laboratory tests, X-rays, and medical equipment. A major feature

of the CHCD, as with other case management systems, was the primary care physicians' responsibility to prior authorize and refer patients to other providers for specialty care that they themselves could not provide. A written referral form was required for specialist physician services, but not for other non-primary services. Since physicians received no case management fees, it was felt that the paperwork demands on case managers should be kept to the minimum.

From the beginning, certain Medicaid recipients were excluded from participation in CHCD: residents of long-term care facilities, lock-in recipients, those in protective custody, children in foster care, general assistance recipients, and certain persons eligible for Medicaid for only a short time.

1.3 GAINING SUPPORT FOR THE PLAN

A. Recipients and Their Advocates

During CHCD's planning stage, the leading welfare advocacy group for Medicaid recipients throughout the state was Utah Issues. DHCF presented the CHCD idea to the Utah Issues director in September, 1981, and to a full meeting of Utah Issues' members in October, 1981. The Utah Issues director and its membership fully supported the CHCD idea. They had previously argued that the problem with Medicaid was that, while recipients had a Medicaid card, they did not know any physicians who would accept Medicaid recipients. Utah Issues recognized CHCD as a way in which Medicaid recipients could get involved in the health care system. In a December, 1983, letter to the DHCF the Utah Issues' director wrote:

> I have monitored the development of case management and found, generally, that it has worked to the benefit of Medicaid recipients. . . . As federal and state resources to provide the poor with health care constrict, we are supportive of alternative modes of delivery that maintain quality of care and encourage fiscal accountability. . . . Our and your objectives happily coincide in the matter of case management.

B. Utah State Medical Association (USMA)

When first told of the CHCD plan, some physician representatives expressed concern about the lack of financial benefit to physicians for participating as

case managers in CHCD. As mentioned earlier, DHCF decided not to pay an additional case management fee to participating physicians, even though other states did. Michigan, for example, was paying an additional $3 per recipient per month to physicians participating in a similar plan.

Other physicians simply did not understand how primary care case management in CHCD worked. For example, some opposed case management on the assumption that they would be assigned undesirable Medicaid recipients. However, CHCD physicians have always retained the right to reject a Medicaid client or to disenroll a recipient from their caseload at any time. Some specialists thought they would lose their Medicaid caseload to "primary care" physicians. However, CHCD allowed specialists to be case managers, so long as the specialist agreed to provide or arrange for provision of the recipient's primary health care.

Most physicians, however, supported the CHCD concept from the beginning. Some, including the USMA's committee on Medicaid, shared the state's concern about inappropriate uses of emergency rooms and had been encouraging the state for some time to do something about the problem. They saw case management as a promising solution worth exploring.

In addition, a large number of physicians supported CHCD simply because it was a good concept and would affect their own practice very little. The program represented no change in either the philosophy or type of care given, and reimbursement was still on the fee-for-service basis preferred by physicians. The only concrete change was the addition of a required referral form, but most physicians simply initiated the form for clerical staff to complete anyway.

Following several initial meetings and considerable discussion, the USMA decided to support the CHCD program. After a short debate about the goals and merits of CHCD, the USMA's Board of Trustees voted to approve the use of its logo on the brochure DHCF would use to solicit participation by Utah physicians. A copy of the brochure is provided in Attachment 1.1.

C. Health Maintenance Organizations

DHCF easily gained support from FHP, the staff HMO. When FHP first came to Utah in 1976, 75 percent of its patients were Medicaid clients. Over time, its private-pay caseload had increased dramatically. By 1981, only 19 percent of FHP's caseload consisted of Medicaid clients. Since FHP's intent was to maintain its Medicaid caseload between 20 and 25 percent, the HMO participated in CHCD from the beginning in the hope of attracting and retaining additional Medicaid clients.

DHCF failed to obtain the support of HMO Utah, the Blue Cross/Blue Shield IPA-type HMO. HMO Utah supported CHCD initially, even to the point of preparing an introductory brochure, but they balked upon program implementation. Blue Cross/Blue Shield argued that Medicaid clients represented too great a financial risk. This was an unfortunate decision, since HMO Utah provided the state-wide coverage needed to allow the implementation of CHCD into Utah's rural areas.

D. Reasons for Success

With the exception of HMO Utah, DHCF obtained support for CHCD quickly and easily, for three main reasons. First, DHCF consulted welfare rights groups and medical societies in developing the design of the program. This involvement encouraged a ready acceptance of the program and allowed for effective early implementation.

Second, the hard work of designing, developing, and implementing CHCD was conducted by DHCF. Neither the medical societies nor FHP were asked to devote money or manpower to developing the project. At that time, the USMA had no full-time staff and was quite willing to let DHCF staff coordinate the project.

Third, and perhaps most important, Dr. James Mason, then Director of the Utah Department of Health, is a widely respected physician who enthusiastically and actively promoted the CHCD concept. This contribution by Dr. Mason, who later became head of the U.S. Centers for Disease Control in Atlanta, was ex-

tremely important. One of the 22 members of the USMA Board of Trustees, and a member of the Utah Academy of Preventive Medicine, Dr. Mason attended numerous state and local medical meetings to speak on behalf of CHCD.

It is important to note that official Utah legislative approval of CHCD was not required and that the state legislature took no direct role in developing or implementing the initiative. In retrospect, DHCF staff speculate that one reason for the legislature's lack of involvement was the influence of Dr. Mason. In addition to his stature within the medical community, Dr. Mason was highly respected by both the state administration and the legislature.

1.4 GETTING STARTED

A. Pilot-Testing the CHCD Concept

For a number of reasons, DHCF decided to pilot-test the CHCD concept before large scale implementation. DHCF wanted to work out details of recruiting physicians, enrolling recipients, and administering the program. Welfare advocates wanted to see how the program would affect Medicaid recipients in real life. Physicians wanted to see how primary care case management would affect their caseloads, practice patterns, and reimbursement levels. It was agreed in the beginning that the pilot project should test the workability, not the success, of CHCD.

DHCF selected Weber County for the pilot project because of its relatively large Medicaid population and its location just north of Salt Lake City. Medicaid recipients were offered the choice of enrolling with FHP or a fee-for-service primary physician as their gatekeeper to Medicaid services. Since the pilot project was not mandatory for Medicaid recipients residing in Weber County, it began on November 1, 1981, before Utah had requested a federal waiver. If successful, the pilot project would provide a basis on which the state could confidently apply for a federal freedom of choice waiver, which would make CHCD mandatory for most Medicaid recipients.

According to the initial pilot plan, local public assistance case workers

were to explain the CHCD to current and newly eligible Medicaid clients and help them decide whether to join FHP, sign up with an enrolled primary care physician, or continue to receive care as they had in the past. Shortly after the pilot began, however, DHCF recognized that the CHCD was, understandably, a low priority for the case workers, whose primary mission was to determine eligibility for cash assistance. What was needed was specially designated Medicaid staff who had a direct stake in the success of the managed health care program. Therefore, after a brief transition period during which the DHCF's CHCD coordinator, Carol Thomas, worked directly with Weber county recipients and providers, the position of Health Program Representative (HPR) was created to fulfill that role. Now, immediately after a person is certified for Medicaid assistance, she/he meets with a locally-based HPR, who helps in selecting an HMO or physician option and a specific provider within close geographical limits, and provides basic education in how to maintain continuity of care.

According to DHCF staff, this change from using caseworkers to using HPRs for CHCD enrollment and assistance was one of the most significant, strategically; it accounts for much of the success in enrolling both recipients and physicians in the CHCD.

One definition for success of the pilot-test was to be the way in which the involved participants responded to CHCD. The pilot project lasted for approximately one year, and both recipients and physicians responded very well. For example, the majority of recipients selected the primary care physician option, and most others chose the FHP. Very few recipients decided not to join one of the two available forms of managed care, although the option to maintain the status quo was available.

Recruiting physicians also proved to be an easy and quick task. Dr. Mason and key DHCF staff attended a Weber County Medical Association meeting to present CHCD, and the Medical Association agreed to support the program. However, no active steps were taken by the local association; they did not directly inform their physicians about CHCD nor did they publicize it in their newsletter.

In November, 1981, physicians with Medicaid provider numbers in Weber County received a letter from DHCF indicating that Medicaid clients in Weber would be offered the CHCD option beginning December 1, 1981. The letter requested that interested physicians notify the USMA or DHCF for additional information. Between 50 and 60 physicians called to request additional information.

B. Obtaining Federal Waivers

Since the pilot in Weber County was successful, the DHCF quickly proceeded with plans to implement CHCD on a broader scale. Section 1915(b)(1) of the Omnibus Budget Reconciliation Act of 1981 made it possible to obtain a change in the Medicaid requirement of "free choice of provider" by applying for a waiver from the U.S. Department of Health and Human Services. On November 2, 1981, Utah requested a waiver of section 1902(a)(23) of the Social Security Act in order to establish a program requiring Medicaid recipients to choose between an HMO (FHP or, initially, HMO Utah) or a primary care physician. The proposal also incorporated under the authority of Section 1915(b)(2) the use of the State Health Department and the Department of Social Services to act as "a central broker" to assist individuals in selecting a case management provider.

The relevant section of 1915(b) states:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 and section 1903(m) as may be necessary for a State:
>
> (1) to implement a Case Management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain primary care service (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary.

The waiver was granted, effective March 23, 1982. Utah was one of the first states to request and receive approval to implement a primary care case management program. With the waiver approved, CHCD was implemented in the four

most populous counties in Utah: Salt Lake, Weber, Davis, and Utah. These four adjacent counties along the Wasatch Front contain over three-quarters of the entire population in Utah's 29 counties. On March 23, 1984, the waiver was extended for two more years to allow Utah "to continue to conduct and expand upon an effective case-management program".

C. Establishing a Provider Agreement

For a physician to serve Utah Medicaid clients, the physician must complete a "Non-Institutional Medicaid Provider Application" and sign the "Utah Medicaid Provider Agreement". The application provides DHCF with information needed for an efficient payment process, and the agreement ensures that the physician practices medicine within the scope of Utah law.

Case management under the CHCD plan did not involve any other signed agreement between the physician and DHCF. Physicians were notified by DHCF about the increased responsibilities involved in the role of gatekeeper (Attachment 1.2). As case managers, physicians were solely responsible for ordering laboratory and x-ray studies, prescribing medications (except for specialists designated by them), and managing health care. Referrals to specialists required a special form, and patients were instructed to contact the primary care case manager first when emergencies occurred. Physicians were not legally bound to fulfill these gatekeeper responsibilities. Nor were physicians, other than, perhaps, those on staff at an HMO, held fiscally responsible for the Medicaid recipients in their caseload. In short, primary care case management physicians had no official agreement with DHCF beyond their original agreement to serve in Medicaid.

1.5 CONCLUSION

Perhaps the most remarkable characteristics of Utah's Choice of Health Care Delivery (CHCD) program -- and what distinguishes it most from Michigan's Physician Primary Sponsor Plan -- are its simplicity and its smooth, uneventful

beginning.(1) Mandatory for most AFDC and SSI Medicaid eligibles and therefore mandatory for Utah physicians who wanted to treat Medicaid recipients, the CHCD represented a simple choice for all concerned. Further, as will be seen in the next chapter, CHCD's objectives and requirements were few and uncomplicated.

The CHCD promised only minor change in how physicians delivered services -- unlike Michigan's program, no contract was required -- and physician acceptance was easily obtained. As well, the CHCD was well received by the state's major welfare advocacy groups, who agreed that change was needed. Utah was also able to learn from some of Michigan's mistakes; for example, the CHCD was first tried in one pilot county before large-scale implementation was attempted, and that was done on a phased-in basis.

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1. For comparison, see James Bell, Helen Rosenthal and Larry Beyna, Michigan's Physician Primary Sponsor Plan: Implementing Primary Care Case Management in Medicaid, Medicaid Program Evaluation Working Paper 4.2, James Bell Associates, Inc., February, 1987.

CHAPTER 2
OBJECTIVES, DUTIES AND RESPONSIBILITIES UNDER CHCD

2.1 OBJECTIVES

Early in the CHCD program the Utah Department of Health, in cooperation with the Utah State Medical Society, produced and distributed widely a brochure explaining the purposes and operations of the new case management program. According to this brochure, CHCD was developed to (1) "provide recipient access to mainstream medical care", (2) "better manage recipient use of medical services", and (3) "contain costs in Medicaid while paying equitable fees to physicians." Each of these three objectives is discussed below.

A. Provide Recipients Access to Mainstream Medical Care

The main reason Utah Issues, the recipient advocacy group, was willing to support CHCD was the general belief that too many Utah Medicaid recipients were unable to find a physician who would accept them as a patient. DHCF statistics (reported in the initial waiver request) showed that only 20-25 percent of the Utah physician population were willing to serve Medicaid clients. As a result, many recipients were receiving medical care (e.g., through multiple providers or emergency rooms) which both diminished quality and continuity of care and increased Medicaid expenditures. Utah Issues and DHCF saw CHCD as one way to correct these problems by mandating that each recipient be matched with a primary physician who would help the recipient to obtain any needed diagnoses and treatments.

The increased access was expected to manifest itself in a variety of ways, including:

- An increased number of physicians willing to participate in the Medicaid program.
- Increased ability for recipients to find physicians who would accept them as patients. Since DHCF helped each recipient obtain a primary physician, CHCD should theoretically leave no Medicaid recipients without a "personal doctor."
- A more productive physician-patient relationship, which allowed for improved knowledge of the patient, less time spent on duplicative diagnosis and treatment, increased compliance with diagnostic and therapeutic procedures, and improved patient education on important topics such as preventive care.

B. Better Manage Recipients' Use of Medical Services

While DHCF wanted to improve recipient access, it was also interested (perhaps even more interested) in increasing recipients' use of appropriate medical services and decreasing their use of inappropriate medical services. One example cited during program development was a client who was known to see four different orthopedists at the same time. Such clients miss the benefits of continuous, high-quality care from one physician. Instead, they rely on intermittent care from providers who have an incomplete understanding of their medical history and their treatment by other providers.

This better management of the use of medical services was expected to be evident in a variety of ways, including:

- More initial contact with the primary physician. Since CHCD makes one physician responsible for all health care needs, one physician either provides or authorizes all non-emergency care for each recipient. This physician becomes the "gatekeeper" for all medical services to an individual recipient.
- Reduced numbers of both different physicians seen and total specialists seen, since the primary physician authorizes all services and makes any needed referrals to appropriate specialists. Data prior to CHCD showed that many recipients used two to three doctors, but that others used even more.

- Reduced numbers of laboratory tests and x-rays, pharmacy claims, hospitalization days, and emergency room visits, again because the primary physician coordinates all services and eliminates unnecessary or duplicative ones.

- Fewer complaints from recipients about discontinuous or poor quality care.

It is important to note that DHCF did not set specific quantifiable targets for these expected outcomes. This will be important in Chapter 6 when we discuss the progress made toward reaching these goals.

C. Contain Costs in Medicaid While Paying Equitable Fees To Physicians

DHCF predicted that Utah Medicaid expenditures would drop as a result of the better use of medical services. By eliminating unnecessary and duplicative physician services, prescriptions, laboratory tests and x-rays, and emergency room visits, the total number of Medicaid claims would drop for some people, thus saving money for Medicaid. DHCF did not predict, however, how much money would be saved, either by specific type of medical service or overall.

2.2 DHCF RESPONSIBILITIES

The CHCD program is administered by the Division of Health Care Financing (DHCF) within the Utah Department of Health. DHCF is responsible for both operating and enlarging the program. Seven specific major responsibilities are described here.

A. Reimburse Physicians for Medical Services

Reimbursement to case manager physicians is on a fee-for-service basis and is paid at the same rate as in the standard Medicaid program. Individual providers bill Medicaid directly, and these claims are processed on a weekly basis as submitted. The primary physician is not responsible for payments to specialists, labs, or other medical services. Primary physicians must complete a referral form for all specialist care and this form is sent to DHCF. These forms are not routinely used, however, to verify specialist claims for reimbursement. Specialists must include the primary physician's number on all

claims, though.

DHCF considered paying an additional case management or administrative fee to participating physicians, but research indicated that this would cost the state at least $2 million per year. It was decided that physicians would participate even without this expensive incentive. Instead, Utah hoped to share with participating physicians any savings generated by CHCD, perhaps in the form of increased rates of reimbursement for services.

B. Set and Monitor Compliance with Cost-Effectiveness Standards

Two interrelated DHCF objectives are to lower inappropriate service utilization and to eliminate unnecessary expenditures. These goals are not unique to CHCD, however; they apply to the entire Medicaid program. At the time of CHCD implementation, Utah's Medicaid program was installing a new management information system, including a surveillance and utilization review system (SURS) to identify recipients and providers with exceptionally high service utilization (and expenditure) levels. This review system is applied to all Medicaid recipients, including CHCD enrollees.

Another means of monitoring utilization is the Physician Referral Form. (See Attachment 2.1.) Each time a primary care case manager refers a recipient to a specialist for care, a referral form is completed in triplicate, with one copy going to the the DHCF's CHCD coordinator. In this way excessive referral can be flagged and dealt with on a case by case basis.

C. Provide Necessary Reports to Primary Physicians

To ensure that physicians are aware of their CHCD patients, DHCF planned to provide, and now does provide, each physician with a quarterly list of all the Medicaid eligibles enrolled under him or her as case manager. Since almost all Medicaid recipients would be in CHCD, this list would remind a physician of his or her Medicaid primary care caseload. DHCF was also prepared to provide, on a per request basis, a detailed listing of all bills paid for any patient.

D. Enroll (and Disenroll) Recipients

CHCD is mandatory for almost all Medicaid recipients. All but those who are exempt must choose, with the help of a Medicaid Health Program Representative (HPR), either a primary physician or an HMO. (As of September, 1986, there were three HMOs involved in the CHCD, two staff HMOs and one IPA). If the Medicaid enrollee chooses an HMO or requests a particular physician, the HPR simply records that choice and begins the appropriate administrative procedures. (See Attachment 2.2.) If the enrollee desires a primary physician but has no one in mind, the HPR helps match the recipient with a participating physician in the local area. In either case, the HPR confirms by telephone the physician's willingness to accept this particular person and then the DHCF prints the physician's name or the name of the HMO on the person's Medicaid card.

Initially, those enrolled with a CHCD case manager were required, with some exceptions, to remain with their chosen providers for 12 months. Now, however, according to Federal regulations, they can change as often as once a month if they wish. However, while CHCD enrollees do have the right to disenroll from a provider "upon reasonable notice and for a justifiable cause", they cannot disenroll from case management itself. All requests for a change of physician are reviewed by DHCF and the person requesting the change must be personally interviewed by the Medicaid HPR. (The forms used for change of provider from case management into an HMO and disenrollment from an HMO are provided in Attachment 2.3.) If a request for a change is denied, an administrative review may be requested -- first, an informal hearing and, then, if necessary, a formal one.

E. Sign up Primary Physicians

Just as all eligible Medicaid enrollees must enroll in CHCD, so must all Medicaid primary care providers agree to serve as CHCD case managers. A provider who refuses to participate in CHCD cannot serve eligible Medicaid recipients. Generally, a primary care case manager will be a practitioner in the field of general practice, family practice, pediatrics, internal medicine, or obstetrics/gynecology. Specialists can serve as case managers, too, but few of them do.

DHCF believed that physicians would be more willing to assume the case manager role for Medicaid recipients if they were aware of the goals, purposes, and responsibilities involved in the program. Therefore, one of DHCF's goals was to inform and educate physicians about CHCD. In addition, DHCF planned initially to designate as "preferred providers" those physicians who stressed preventive medicine rather than crisis medicine and whose utilization rates were relatively low. Two physician consultants were to be hired to help identify this type of provider. Recipients would be encouraged to enroll under these and not under physicians with high utilization rates. Since this would, in effect, constitute a "lock-out" program, DHCF was informed by HCFA that a special waiver would be required. DHCF decided to drop the idea.

CHCD physicians also have the right to disenroll a recipient from their caseload upon reasonable notice and for a justifiable cause. Physicians may disenroll recipients either because of personal reasons or because the client would be better handled by some other type of physician.

F. Ensure the Quality of the Services Provided

As for assuring that providers deliver quality care to CHCD participants, DHCF has several means for monitoring and holding accountable the HMOs and case managing physicians who provide services. These mechanisms are described in DHCF's December, 1985, request for waiver extension and a June, 1986, supplement to that request.

HMO Quality Assurance. All HMOs contracting with the state must maintain their own quality assurance programs. In addition, they are subject to quality assurance reviews performed by medical staff within the Department of Health's Bureau of Medical Review. Attachment 2.4 contains a description of the Bureau's program for reviewing managed health care systems.

The Quality Assurance program at Healthwise, one of the HMOs contracting with the state, includes comprehensive reviews and evaluations of patient care and clinical performance to assure appropriate utilization of resources and a safe patient environment. The quality assurance reviews performed by

Healthwise, which are described in detail in Attachment 2.5, include:

- Specific provider, member, and facility audits whenever trends of behavior indicate a significant deviation from established standards.
- Peer reviews, including pre-admission, concurrent, and retrospective reviews by the HMO's Medical Services Department, participating medical groups, and the HMO's Quality Assurance Committee.
- Concurrent inpatient reviews of emergency and elective admissions, including reviews of the appropriateness of length of care, selective reviews of patient charts, and discharge planning.
- Other reviews and monitoring of selected elements of care which are considered key indicators of quality.

FHP, another HMO contracting with the state, also has a well documented quality review and assurance program. In addition, FHP health care professionals are required to maintain an annual program of study to keep abreast of changing medical technology. Physicians and physicians' assistants are required to attend a minimum of 50 hours of continuing medical education each year to remain abreast of the rapid advances occurring in medicine. All FHP physicians' assistants and nurse practitioners are required to be graduates of a nationally approved education program and to have passed a National Certification Test.

Attachment 2.6, a part of DHCF's sample contract for HMOs involved in the CHCD, lists specifications for the HMO's quality assurance plan. In addition, DHCF will be implementing a system of independent quality assurance audits of HMOs to begin with contracts effective in January, 1987. The department will contract with, or require that the HMOs contract with, the National Committee on Quality Assurance (NCQA) to provide these independent audits. NCQA is a national organization composed of medical directors from both group practice and IPA HMOs.

Medical Review. Physicians participating in the case management program are reviewed by the State Bureau of Medical Review. Reviews are performed mainly on an exception basis using profiles generated by the state's Surveillance Utilization Review System. According to DHCF officials, the results of the reviews have not indicated any significant problems with quality of care in the case management portion of the program.

HPRs. Another aspect of the CHCD which leads to improved access and quality of care for Medicaid recipients is the Health Program Representative (HPR). The HPR acts as an advocate for the recipient and provides the information necessary for the recipient to make an informed decision with regard to the CHCD. In addition, the HPR educates the recipient regarding intelligent utilization of available health care services. This helps reduce unnecessary or duplicate medical services. The HPR provides the recipient with a contact person from whom to seek information regarding available services and, if needed, to discuss grievances which the recipient might have regarding the program.

G. Ensure Administrative Resources

Since CHCD operates entirely within Utah's existing Medicaid program, the general resources of DHCF support the case management effort. For example, all billing and reimbursements are conducted as before, with the exception of ensuring that the proper physician's authorization code appears on any bill for a CHCD recipient. This one additional step is automated and therefore requires few additional resources.

Enrolling recipients and signing up physicians are, however, unique to CHCD and do require administrative resources to support the Health Program Representatives assigned to the eight local welfare offices in which the CHCD operates. Administering the program also involves extra resources at the state level. In 1985, there were 10.5 state employees involved in CHCD: 2.5 at the state office, and eight HPRs at the local welfare offices. With the addition of two HPRs to staff the local offices in late 1986, there were 12.5.

2.3 RESPONSIBILITIES OF PRIMARY PHYSICIANS

As the persons responsible for providing and authorizing all care to recipients, primary physician "gatekeepers" are critical to CHCD's success. Their duties fall into three categories.

A. Accept Medicaid Patients Under CHCD

When a physician joins CHCD, either by informing DHCF of his/her willingness to be a case manager or by agreeing to accept a particular recipient when asked by an HPR, he or she commits to becoming that patient's personal primary physician has. Barring logistical or personal problems, the physician agrees to continue treating the recipient indefinitely as part of the regular caseload.

B. Perform Role as Case Manager

Becoming the primary physician means accepting the role of manager for all medical care. This includes providing:

- The majority of health care for the recipient.
- Prior authorization for all hospitalization, specialist care, laboratory tests, x-rays, medical equipment, and prescriptions. Without this prior authorization, other providers will not provide services. The primary physician's number must be on each specialist's claim form in order for the specialist to collect payment from DHCF. Other service providers do not have to provide the primary care physician's number. Prior authorization for them merely consists of verbal referral from the primary physician. Since, reportedly, there is very little abuse of the system in Utah, DHCF felt it was not worth the paperwork to require the primary physician's number on claims for services other than physician services.
- A written referral for all specialists, whether or not the specialist participates in Medicaid or CHCD. Without the special CHCD referral form, specialists will not be reimbursed if they perform services. The primary physician sends one copy of the special referral form to DHCF and one to the specialist. DHCF uses the form for general monitoring and research purposes. The specialist does not submit the referral form when he/she makes a claim. But all specialist claims must bear the primary physician's number (which is provided on the referral form).

  In effect, then, the special referral form itself is a communication tool to facilitate continuity of care, not a control tool. Specialists receiving the referral do not need the primary physician's authorization to order diagnostic tests or treatment for the recipient, but prior verbal authorization is needed for hospital admissions. These referral procedures do not eliminate the possibility of a recipient self-referring to a specialist and the specialist using the primary care case manager's number on a claim form.

- Appropriate coverage, on a 24-hour basis, to recipients in case of medical need. This coverage can be via the telephone, but it is not clear what exactly constitutes appropriate coverage: a home telephone number, an answering machine, answering service for a group of physicians, etc.

- Instructions on emergency care. In the event of an emergency, recipients are to contact their primary physician first. However, if unable to reach the physician, or in a life-threatening situation, recipients are to call the paramedics or go to the nearest hospital emergency room. DHCF does not define gradations of emergency care. If delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health, then emergency care may be given without the primary physician's authorization.

C. Accept Reimbursement from DHCF

All claims for services under CHCD, as under the standard Medicaid system, must carry the appropriate provider number, be subject to standard Medicaid authorization requirements, and be submitted within 12 months from date of service. DHCF then reimburses Medicaid-covered services on a fee-for-service basis at the standard Medicaid rates.

2.4 RESPONSIBILITIES OF RECIPIENTS

Even though recipients theoretically cannot circumvent the CHCD restrictions on services, they could easily destroy the program's effectiveness by refusing to carry out their case management responsibilities. These include participating in the selection of their primary care providers, routinely seeking care from and through that provider, and adhering to emergency care and other procedures. Attachment 2.7, a brochure given to new Medicaid recipients, outlines recipients' rights and responsibilities under CHCD.

2.5 CHCD OVERSIGHT

Outside of routine monitoring of the Medicaid program as a whole, DHCF conducted very little oversight of the CHCD. With the direct involvement of HPRs at the local level and other CHCD staff at the state level, most program problems are identified and resolved early. In addition, Utah Issues, the recipient advocacy group, monitors the CHCD's implementation and impact. In its

letter of support to DHCF, Utah Issues declared that they would watch future developments with interest.

In addition to the procedures for changing primary physicians, there are provisions for a formal grievance process for recipients or physicians. Local and state DHCF staff handle complaints first on an informal basis; if the recipient or physician is not satisfied, the formal grievance process is used.

2.6 CONCLUSION

The CHCD was a relatively simple program, which, like other case management initiatives, promised increased access for recipients and reduced utilization and costs. Other than use of a written form for specialist referrals and maintenance of 24-hour, emergency, and prior authorization procedures, few new responsibilities were given to Medicaid physicians under CHCD's limited gatekeeper approach. Except for those involved in HMOs, perhaps, case managing physicians were not asked to assume new financial risks under CHCD. They could lose some revenues through reduced utilization, however, and they would not receive any case management fees.

These facts -- plus the requirement that primary care physicians participate in CHCD if they wanted to continue serving Medicaid clients -- contributed to relatively high provider participation in the program. Specific details of this participation are provided in the next chapter.

CHAPTER 3
RECRUITING PRIMARY PHYSICIANS

3.1 PHYSICIANS' PREDISPOSITION TOWARD MEDICAID

Prior to CHCD, only about one-fourth of the practicing physicians in Utah actively provided services to Medicaid recipients. Few, if any, of the physicians serving Medicaid recipients had large Medicaid caseloads, so Medicaid-related services did not consume much of an average physician's time. It was estimated that physicians serving in Medicaid saw one to five Medicaid patients per day, out of an average total of 35 appointments per day, and had about one call per month from a Medicaid patient outside regular office hours.

Nonetheless, those physicians not serving Medicaid recipients offered several reasons for non-participation. The most common was that their practice was currently too full. Many of these physicians stated, however, that if their practice opened up, they would accept Medicaid patients. A second reason was that the Medicaid reimbursement rates were too low. Many physicians simply felt they would lose money by serving Medicaid recipients instead of other patients. Third, some physicians saw serious administrative weaknesses in the way DHCF handled the Medicaid reimbursement process. From their point of view, DHCF too often returned or rejected claims for trivial reasons, made keypunch errors while entering data or were slow to reimburse for services. Finally, there were other, more personal reasons why some physicians refused to serve Medicaid recipients. These physicians felt, to varying degrees, that Medicaid recipients were too crisis-oriented, would not practice preventive care or seek help early enough, and were generally harder to manage than other patients.

3.2 INCENTIVES TO JOIN CHCD

The design of CHCD addressed none of these reasons for physician non-participation directly. Participating physicians would be reimbursed at the same rates (with no additional case management or administrative fee), and the same offices within DHCF would be processing claims. Furthermore, while Medicaid recipients were expected to behave differently under CHCD (see Chapter

2), it would be unrealistic to expect them to change their behavior rapidly.

There were at least four possible reasons physicians might be interested in joining CHCD. First, since all Medicaid recipients were required to select either an HMO or a primary physician, it was necessary to join CHCD in order to maintain one's current Medicaid caseload. Otherwise DHCF would require the recipients to choose another physician as their gatekeeper. Second, many physicians liked the continuity of care that case management would provide. Knowing their Medicaid patients' history would reduce the need for costly defensive medicine practices such as duplicative diagnostic tests. Third, DHCF promised in its marketing to physicians (e.g., Attachment 1.1) that it intended to share savings generated by CHCD with participating physicians, perhaps by raising reimbursement rates in the future. Utah physicians wanted higher rates, and some may have seen CHCD as one feasible way to obtain them. A fourth incentive for some physicians was the personal support of Dr. Mason for the CHCD concept.

3.3 EFFORTS TO RECRUIT PRIMARY PHYSICIANS

Any physician in Utah, whether a primary care physician or a specialist, may become a primary physician. DHCF's only requirements are that the physician be responsible for the majority of the recipient's primary care and that the physician have, or apply for, a Medicaid provider number. DHCF does not place a floor or ceiling on the number of Medicaid recipients in a physician's caseload, or require a formal contract specifying CHCD duties. Caseload size has never been a problem in Utah -- e.g., there are no "Medicaid mills" -- and the state has had very few problems with noncompliant providers.

A. Gaining Respected Endorsements

DHCF realized it needed endorsements from respected physicians if it was to recruit a sufficient number of Utah physicians into CHCD. The first critical endorsement came from Dr. Mason, whose prestige and position allowed him to advocate the program to a wide audience. Dr. Mason's many appearances before state and local medical associations added credibility to the state's plans for

the new program and may have influenced physicians who were uncertain about their own views.

Also important was the endorsement by the Utah State Medical Association (USMA), whose decision to allow DHCF to use its logo on marketing brochures added credibility to the plan. Even though USMA did not recruit individual physicians or even actively encourage them to join CHCD, its formal support removed one potentially serious obstacle to physician acceptance.

B. Specific Techniques for Recruiting

Having gained these endorsements, DHCF used a variety of ways to recruit individual physicians into the CHCD program:

- In May, 1982, all physicians with a Medicaid provider number were mailed a CHCD brochure, which described the program and showed the high utilization patterns under the current program. About 230 physicians returned the enclosed application form and were then placed on an official list of providers willing to assume the role of primary physician for Medicaid recipients.

- Some recipients requested a specific, geographically convenient physician from their area or chose one from the telephone book. When this occurred, local Medicaid staff, the HPRs, called the physician to request that he or she accept this particular recipient as a CHCD patient. If the physician agreed, he or she automatically became a CHCD physician.

- Every two years, each Medicaid physician must sign a new Provider Agreement Form to remain certified to treat Medicaid recipients. In September, 1982, DHCF sent physicians a CHCD brochure and application along with the Provider Agreement forms. (A copy of this brochure is provided in Attachment 1.1.) By November, 1982, there were 313 primary care physicians who had agreed to participate in the CHCD.

- When the Utah Department of Health installed a Medicaid Management Information System (MMIS) in April, 1983, DHCF trained Medicaid providers in the new billing procedures. DHCF also used this training session to educate providers in the entire State about CHCD.

- Physicians have access to the CHCD telephone hotline, which provides information on the program to providers and recipients.

- A description of the CHCD is provided in the Medicaid provider's manual.

- Finally, the locally based HPRs sometimes have the opportunity to remind physicians in their area about CHCD. For example, when a new HPR began working in Provo in September, 1984, she mailed CHCD information as part of an introductory letter to all Medicaid physicians in her area.

3.4 SUCCESS OF PHYSICIAN RECRUITMENT EFFORTS

The success of DHCF's recruitment efforts can be assessed in two ways: (1) the number of physicians applying to serve Medicaid recipients under CHCD, and (2) the number of physicians willing to accept a specific Medicaid recipient if asked to become the recipient's primary physician.

A. Applications to Join CHCD

Originally, DHCF hoped to recruit most Medicaid physicians by using the introductory brochure and application. If so, DHCF could then compile an official list of all CHCD physicians and simply have recipients choose a physician from that list. This procedure would be easiest for the recipient, physicians, and DHCF. Unfortunately, only 30 percent of the Medicaid physicians returned the application form following receipt of the CHCD brochure. This meant that a smaller number of physician names could be listed on the CHCD roster, too few to serve the necessary number of recipients.

B. Agreements to Accept Medicaid Recipients When Asked

DHCF learned from the pilot project that HPRs did not need a formal and complete list of physicians interested in CHCD, since almost all Utah physicians are willing to accept a Medicaid recipient when asked to do so by DHCF. During the pilot project, no physician rejected any recipients, and only a small number of physicians have refused Medicaid recipients since CHCD was implemented on a broader scale. (It is our impression that physician cooperation has been partly the result of aggressive marketing on the part of CHCD administration and HPR staff throughout CHCD's early years.)

CHCD officials report that the number of physicians participating in Utah's Medicaid program has increased. In the absence of hard data on pre-CHCD par-

ticipation, it is impossible to validate the claim. By June, 1983, over 2,800 physicians had signed up to participate in CHCD either as primary physicians or as specialists. By May, 1984, this figure had risen by 300 to over 3,100. According to the most recent waiver extension request, there were 616 primary care physicians and 65 clinics actively providing CHCD services in April, 1986. Clinics average about seven physicians per clinic, so the total number of primary care physicians in CHCD was about 1,071. According to another estimate, there were about 1700 primary care physicians serving CHCD recipients in the four Wasatch Front counties in late 1986.

C. Disenrollments

This successful recruitment would be negated if physicians who joined CHCD, became unhappy with the program, and soon thereafter disenrolled all or most of their CHCD recipients. Physicians do have the right to terminate their relationship with recipients "upon reasonable notice and for a justifiable cause". At the time of the study, there were no data on how many disenrollments have occurred, but DHCF believes the number to be very small.

3.5 CONCLUSION

From the data available, it is difficult to assess objectively the success of Utah's efforts to recruit physicians for the CHCD. While the numbers of physicians joining CHCD were low at first, there never appeared to be any major problem with linking recipient enrollees to case managers. If asked, physicians typically agreed to serve.

This cooperation, plus the personal attention of HPRs to each recipient enrollee's needs, made recipient enrollment a relatively smooth process. In other states' case management programs -- e.g., Michigan's -- the slow involvement of primary care physicians caused more serious recipient enrollment problems. Utah's experience with recipient enrollment is described in the next chapter.

CHAPTER 4
ENROLLING MEDICAID RECIPIENTS

4.1 TARGET POPULATION

As of July, 1983, there were 58,137 Medicaid recipients in Utah. After those not eligible for CHCD were excluded (2,708 general assistance recipients and 4,982 long-term care recipients), there were about 50,477 remaining CHCD eligibles. About ninety percent (45,429) of these were AFDC recipients, and the remainder were aged, blind and disabled and medically needy children.

These 50,477 potential eligibles for CHCD accounted for approximately $63,977,700, or 52 percent, of the FY 1982-83 state Medicaid budget (excluding nursing home expenditures). The medical expenditures per year for these CHCD eligibles averaged $1,267 in 1982-83.

Approximately 80 percent of the 50,477 CHCD eligibles lived in the four most populous counties of Weber, Davis, Utah and Salt Lake. This area, called the Wasatch Front, was and still is the only part of Utah served by HMOs (four as of late 1986). The other 20 percent of eligibles were spread over the remaining 25 Utah counties in small cities and towns of 20,000 or fewer people.

Utah's population is predominantly white (93 percent), so most of the potential CHCD eligibles were also white. Some Utah minorities, especially American Indians, suffer from disproportionately high unemployment and use of Medicaid and therefore were prominent among CHCD eligibles.

4.2 INCENTIVE TO ENROLL

During the pilot project, recipients could choose between enrolling in CHCD or continuing in the old system. After the success of the pilot project and waiver approval, however, DHCF began to implement CHCD in the four counties and made enrollment mandatory. Except for those relatively few persons excluded from CHCD, all eligible Medicaid recipients were required to choose, with the help of locally assigned Medicaid HPRs, either a private primary physician or an

HMO. The basic incentive to enroll was simple: a recipient was required to do so in order to continue using Utah Medicaid services.

Other states have had less success with mandatory enrollment. In Michigan, for example, the mandatory enrollment policy was not accepted unequivocably by the recipient community, particularly the welfare advocacy groups. This difference over the presence of a mandatory enrollment policy made it easier for recipients, and even social services case workers, to resist mandatory enrollment.

4.3 EFFORTS TO ENROLL RECIPIENTS

Medicaid HPRs in eight local offices in the four target counties coordinate the assignment of each eligible Medicaid recipient to a single primary physician or HMO. These staff are responsible for insuring that recipients "comply" with the limitations of CHCD. Both their physical proximity to recipients and their involvement during the eligibility determination process make this task easier. As of late 1986, there were ten HPRs, eight assigned to specific offices on the Wasatch Front, and two serving where needed in the entire four-county area.

When local public assistance staff determine that an applicant is eligible for Medicaid, the locally-based HPR then explains the CHCD program and helps the recipient choose between an HMO and a primary physician. If the recipient chooses an HMO, the HPR forwards the recipient's name to the HMO, which then contacts the recipient directly.

If the recipient prefers an individual physician, (or if the recipient lives in an area where HMO coverage is not convenient), Medicaid staff help the recipient select a primary physician. This generally occurs in one of four ways. First, the recipient can request a certain physician, usually his or her current physician. Second, Medicaid staff can recommend a local physician known to be willing to accept new Medicaid patients. Third, the recipient can review a list, updated annually, of physicians who have formally applied to be CHCD providers, to select one with the appropriate specialty or location. Finally, the recipient can select a physician from the local telephone book. When the

recipient chooses a CHCD provider, the HPR enters the choice directly into a computer terminal and creates a file on the recipient's participation in CHCD. With a computer terminal at each HPR's service, recipient data can be entered, reviewed and deleted very conveniently and efficiently. Besides managing recipients' involvement in the CHCD, HPRs are also responsible for establishing other third party liability for health coverage.

4.4 SUCCESS OF RECIPIENT ENROLLMENT EFFORTS

By mid-1983, after one year of CHCD implementation, 12,400 recipients were enrolled with a primary physician and about 3,100 were enrolled in FHP, the HMO alternative at that time. These 15,500 represented 31 percent of the total 50,500 statewide targeted population and about 41 percent of the CHCD eligibles living in the four Wasatch Front counties.

Four times as many eligibles enrolled in case management as did the HMO. Besides the existence of a prior doctor-patient relationship, recipient choices were based, for the most part, on convenience of the provider's location. By December, 1985, three and one-half years since CHCD had begun, there were 27,653 eligibles enrolled in case management and 7,090 enrolled in HMOs. Together, these enrollees represented 66 percent of an eligible 52,630 recipients. Most of the remaining eligibles lived in the rural counties outside the Wasatch Front.

As of June, 1986, there were 13,525 recipients (out of about 50,000 CHCD eligibles) enrolled in one of the three HMOs available on the Wasatch Front. This increase suggests that, in recent years, proportionately more recipients have been choosing HMOs. Since there are no data on factors that could affect further patterns of enrollment, such as the relative satisfaction of those with primary physicians compared to HMO case managers, it is difficult to predict whether HMOs will continue to increase their share of CHCD enrollees. Our guess, however, is that, while many recipients may continue to choose individual physicians rather than HMOs, many of the physicians will eventually affiliate with IPA-type HMOs. As a result, their CHCD enrollees will be counted as having chosen an HMO, but that choice will have been based on the primary physician's

characteristics, not those of the capitated plan he or she represents.

A. Unenrolled Rural Recipients

Although the initial CHCD target included all the eligibles in the state, it became clear early in the program that enrolling rural recipients would be difficult, partly because there were no HMOs available and case management was not very different from the customary physician-patient relationship in rural areas where providers are scarce. As a result, the 13,000 rural CHCD eligibles were not pursued during the early years of the program.

In the 1984 waiver request, DHCF proposed expanding the CHCD program into Utah's rural areas through development of a "Rural Health Network" of primary care physicians, including some HMO providers. As did the HPRs in the urban areas, a specially designated team of rural HPRs would enlist providers and help recipients select primary physicians. In addition, the team would work actively to promote HMO growth where capitated systems were feasible and train providers and recipients in ways to improve service quality and to reduce costs.

Fourteen rural towns were initially targeted for this effort. The stated goals of the Rural Health Network were to get 90 percent of all eligible AFDC clients enrolled in case management and, at the end of three-years, have 20 percent of those clients in capitated programs.

As of September, 1986, the CHCD was not yet operational in the rural counties, but DHCF had made considerable progress in that direction. Under an agreement with DHCF, rural local health departments will initially serve as the CHCD brokers -- enrolling Medicaid recipients under case manager physicians. In return, the departments will receive a small monthly fee for each client they enroll. (See Attachment 4.1 for DHCF's Memorandum of Agreement with local health departments.) Once DHCF is able to contract one or more HMOs to offer service to Medicaid recipients in a particular rural area, then a DHCF Health Program Representative will be placed in the local DHSS office serving that area.

According to state officials, this use of the rural local health departments to support the CHCD enrollment process was part of a larger effort by local health departments to strengthen their role in the Medicaid program. In the Wasatch Front area, the health departments were increasing their Medicaid immunization and EPSDT screening activity -- some were providing these services on contract to the HMOs. In some urban areas, local health departments would soon be serving as primary care case manager providers with their own referral systems, like the HMOs. These local departments would still be reimbursed on a fee-for-service basis, though.

B. Disenrollments

Recipients are expected, though not required, to remain with their originally chosen case manager for 12 months, but they do have the right to change providers for either logistical or personal reasons. All requests for change are reviewed by DHCF, and the recipients are personally interviewed by an HPR. If disenrollment is approved, the recipient must enroll with another case management physician or an HMO. The recipient can request an administrative review if the change request is denied. Disenrollment from an HMO requires the recipient to do so in person with an HPR. Recipients are required to work out any problems with an HMO representative within five days or disenrollment takes place. If disenrolled, the recipient must enroll with a case management physician or another HMO.

At the time of this study, there were no data available on the total number of CHCD enrollees changing providers, but some changes have been recorded. During the first four months of 1986, an average of 107 recipients per month disenrolled from their HMO provider and went to a private case management physician. With an average of about 13,000 recipients in HMOs each month during that period, the disenrollment rate was about 0.8 percent. There are five main reasons given for changing from HMOs to private physicians: (1) the recipient prefers to be treated by a doctor whom he/she already knows, (2) the recipient has moved and the HMO is no longer geographically convenient, (3) the recipient dislikes HMO procedures, such as authorization, (4) the recipient has had HMO scheduling problems, and (5) the recipient prefers the personal attention

provided by a private physician. Attachment 4.2 contains a standard questionnaire which is administered to all recipients who wish to disenroll from an HMO. If a recipient changes providers often, he or she is eventually referred to the lock-in program for mandatory assignment by the state to a particular provider.

4.5 CONCLUSION

Recipient enrollment in the four Wasatch Front counties was relatively fast, orderly, and complete compared to that experienced in Michigan's case management program. The major reasons for this difference are quite evident. First, Utah has always considered CHCD participation to be mandatory (with no right to refuse, as in Michigan's program), and recipients have almost universally accepted that fact. Second, the use of specially designated HPRs to enroll recipients at Medicaid certification and redetermination has given the program an effective local presence and individualized treatment of recipients, thus minimizing disruptions and other problems at enrollment and thereafter. While these local staff have been expensive, as will be seen in Chapter 5, they appear to have been well worth the expense, in terms of smooth program operations.

CHAPTER 5
ADMINISTERING CHCD

Within the Utah Department of Health, the Division of Health Care Financing (DHCF) has responsibility for administering all aspects of the CHCD. To a large degree, the success or failure of CHCD depends on how well and how completely DHCF fulfills its administrative duties, which are described in this chapter.

5.1 PROVIDE SUFFICIENT ADMINISTRATIVE RESOURCES

Exhibit 5.1 presents data on program administrative costs for SFYs 1984-1988. These data are from a supplement to DHCF's most recent waiver extension request (July, 1986). Administrative costs are broken down into three categories: (1) staff expenses, including those for locally-based HPRs and state Bureau personnel; (2) office expenses at the state level; and (3) office expenses for the HPRs at the local level.

In SFY 1984, Utah provided 10.5 state employees on a full-time basis. At the state level (2.5 staff), this included one CHCD manager, one research assistant, and a half-time secretary. At the local level (8.0 staff), it included one HPR at each of the four counties' eight target area Medicaid offices. In SFY 1984, all these staff cost $287,000.

In SFY 1986, Utah counted the cost of 14.5 state employees among the costs for the CHCD. These 14.5 employees consisted of the 10.5 employees listed above, plus two additional HPRs and two Health Program Specialists, one to administer HMO contracts and one to administer the process for competitive contracting with HMOs. As shown in Exhibit 5.2, these 14.5 employees are part of the Bureau of Managed Care (formerly the Bureau of Client and Provider Services) in DHCF. The Bureau is headed by a Director, who has a secretary, but these individuals' salaries and fringe are not counted in CHCD cost estimates.

Exhibit 5.1 shows significant increases in administrative costs over time. These increases primarily reflect increases in CHCD staff at both the state Bureau and local office levels. As CHCD expands -- with more enrollees and more

EXHIBIT 5.1

CHCD ADMINISTRATIVE EXPENSES, SFY 1984-1988

	1984	1985	1986	1987(1)	1988(1)
Staff Expenses (salaries, benefits, etc.)	$287,000(2)	$348,000(3)	$394,000(4)	$600,000(5)	$675,000(6)
Office expenses: Administrative (space, supplies, equipment)	21,477	22,607	23,797	24,050	24,175
Office Expenses: Community Operations Offices (space, equipment)	14,500	15,200	16,000	19,500	22,900
Total	$322,977	$385,807	$433,797	$643,550	$722,075

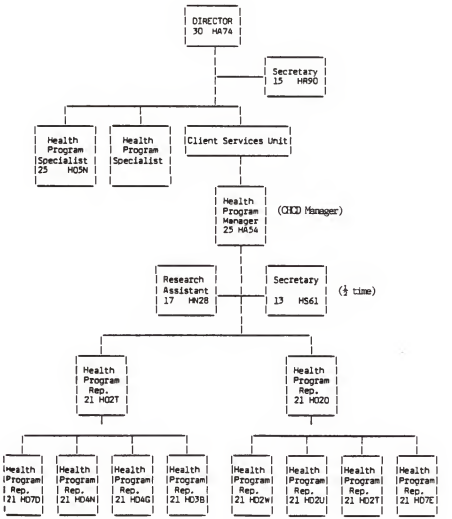
(1) Projected.
(2) Includes eight HPRs, and 2.5 Bureau staff.
(3) Includes two new HPRs.
(4) Includes two new program specialists on the Bureau staff.
(5) Includes four new HPRs, two quality assurance specialists and one reimbursement specialist.
(6) Includes two new HPRs.

Source: Division of Health Care Financing, "Supplement No. 2 to the Application for Continuation of Waivers (Dated December 30, 1985) Under Section 1915 of the Social Security Act," July 31, 1976.

HMOs involved -- staff needs will increase.

The use of specially designated HPRs to administer the CHCD at the local level is one of the most distinctive characteristics of Utah's approach to case management. It is our impression that this investment in staff effort has been a very wise move. The more individualized attention given enrollees early in the program, the fewer the subsequent problems.

EXHIBIT 5.2
BUREAU OF MANAGED HEALTH CARE
(Division of Health Care Financing)



Source: Division of Health Care Financing, "Supplement No. 2 to the Application for Continuation of Waivers (Dated December 30, 1985) Under Section 1915 of the Social Security Act," July 31, 1976.

Beyond direct staff time, necessary administrative resources to get the CHCD started have included indirect staff time from DHCF management, written brochures, mass mailings, facility and equipment rental, a tollfree hotline for providers and recipients, and adjustments and enhancements to the management information system. Most of these costs, but not all, are represented in the other two expense categories.

It is impossible to cost out the information system changes -- claims controls, provider and recipient files, etc. -- since, Utah converted to an automated system at the same time as CHCD implementation. CHCD requirements were built right into the new system, so the cost of the CHCD-required system enhancements is obscured.

5.2 PROVIDE CHCD INFORMATION TO RECIPIENTS AND PHYSICIANS

Since CHCD is a departure from the existing Medicaid program, DHCF has to inform recipients and physicians about the change and how it will affect their dealings with each other and with DHCF. Recipients are informed by Medicaid HPRs and are required to choose a provider when they are declared eligible for Medicaid. This personal explanation from the CHCD HPR is augmented by written explanations in the Medicaid handbook given to all recipients and a sound and slide show available at the local social services offices. Any questions or complaints are addressed by the HPRs and the state staff.

Since it is harder to inform all eligible physicians -- because they are not required to enroll in CHCD -- DHCF has used several channels. In May, 1982, all physicians with a Medicaid provider number received the CHCD brochure and a recipient utilization chart illustrating the overuse of physician and pharmacy services in Utah. This brochure explained why CHCD was developed and how it was expected to decrease overutilization of health care. Any physician who enrolls receives a CHCD brochure, the overutilization chart, and a three-page case management information sheet outlining physician responsibilities (Attachment 1.4).

DHCF also established a toll-free "Medicaid Hotline" for physicians and recipients. Physicians may use the hotline to learn more about CHCD, ask about a specific recipient, or lodge a complaint or problem. Recipients may use it to obtain information or lodge complaints. DHCF reports that the hotline is used heavily. During an eight-day span in June, 1984, an average of 417 calls per day were received. Almost all of these calls were taken in sequence, with an average holding time of 31 seconds. However, almost 110 calls per day (26 percent) required holding over 60 seconds. Whether because of this delay or for other reasons, almost 25 calls per day (6 percent) were abandoned before hotline staff could respond. As of late 1986, six telephone lines were available for reception of Hotline calls. One of these was dedicated to physician's calls.

5.3 MONITOR PHYSICIAN COMPLIANCE WITH DUTIES

While it is important that DHCF provide resources and information for CHCD, it is more important that DHCF make sure that physicians are complying with their duties under CHCD. If physicians <u>are</u> complying the CHCD is expected to reduce Medicaid costs while maintaining quality care for recipients. If physicians are <u>not</u> complying, costs will likely stay the same (or even increase) and recipients' care might suffer. Accordingly, DHCF must ensure that physicians meet their responsibilities, as outlined in Chapter 2.

For CHCD to be effective, individual physicians must be willing to accept responsibility for the overall care of a Medicaid recipient. While only 30 percent of Utah's Medicaid physicians originally applied to enroll in CHCD, almost all Utah physicians will accept responsibility for Medicaid recipients when asked to do so. DHCF administers this process by maintaining and updating the official list of CHCD enrolled physicians and by staying abreast of which other physicians would accept a Medicaid recipient if asked.

To ensure that all physicians are aware of the recipient's case manager, DHCF provides the chosen physician with written notice of his or her new patient and also records, by computer, the physician's name on the recipient's Medicaid card. This latter procedure informs other providers that they will not be reimbursed for services not authorized by the gatekeeper physician.

More recently, DHCF has developed a quarterly report that lists all the eligible Medicaid recipients for whom each CHCD physician has responsibility. Before this listing, physicians had to maintain their own record of their CHCD enrollees. Other physicians can identify a recipient's gatekeeper by the primary care physician's name on his or her Medicaid card. If a client does not have proof of eligibility, the physician should require the client to produce an eligibility letter or a temporary provider letter from his or her caseworker. The physician can call the caseworker or the Medicaid hotline. Unless the physician does this, he or she might run the risk of treating a recipient and later being denied reimbursement from DHCF.

When a physician accepts a recipient, he or she agrees to become the primary physician for that recipient. Even though physicians are not technically under contract with CHCD, their participation implicitly involves agreeing to provide the principal amount of health care, prior authorization and referrals, 24-hour coverage, and quality care. The first three of these are discussed earlier in Chapter 2. In general, DHCF's monitoring of physician activities under CHCD is little different than physician monitoring for the Medicaid program as a whole. According to state staff, abuses of the system are very rare and a general climate of trust and cooperation exists between DHCF and Medicaid providers.

DHCF does monitor HMO performance with respect to key case management requirements. Shortly after signing up with an HMO, enrollees receive a brief DHCF questionnaire regarding their orientation to and understanding of HMO procedures. As of September, 1976, 689 questionnaires had been returned to DHCF. Of those 89 respondents, 94 percent reported that they understood how to use their HMO plan, 96 percent were told how to use their primary physician or medical facilities (depending on the particular HMO), and 92 percent said they knew how to get emergency care. Only 79 percent were told how to register a complaint, however, and 85 percent were given a contact name or number to use if they needed help. (Attachment 5.1 contains a copy of the questionnaire and the data collected to date.)

5.4 CONCLUSION

Since the beginning, CHCD administration has been heavy on personal attention to facilitating enrollment and program participation among Medicaid providers and recipients, and light on systematic monitoring to ensure that its basic requirements, e.g., referral procedures, are strictly followed. This approach stems from CHCD officials' strong commitment to make sure that the program is attractive to providers and recipients alike. It appears that the dollars that might be lost through a more or less laissez-faire approach to monitoring and enforcement are considered more than offset by the positive public relations and positive effects achieved through the intensive labor commitment to enrollment, information and problem-solving. As well, Utah officials feel that without a case management fee or other compensation, the burden on physicians needs to be minimal to maintain their participation.

CHAPTER 6
PRELIMINARY PROGRESS TOWARD CHCD OBJECTIVES

As of this writing, the CHCD has been in operation for over four years in the four most populous of the state's 29 counties. Based on this experience, the program is now being expanded into the rural areas of Utah. This chapter discusses progress to date on each of CHCD's three major objectives: to enhance access, to improve the management of services, and to contain Medicaid costs.

6.1 ENHANCE RECIPIENT ACCESS TO MAINSTREAM MEDICAL CARE

Prior to CHCD, over 70 percent of Utah physicians did not participate in the Medicaid program, either because they had never been asked or because they refused to do so. As a result, some Medicaid recipients could not find a physician who would be their "personal doctor". Recipients relied instead on a variety of different providers and/or hospital emergency rooms for their medical care. Both the continuity and the quality of their medical care suffered as a result.

CHCD officials believe that more Utah physicians have begun to participate in Medicaid since CHCD implementation. Unfortunately, there are no data available to support this contention directly. It should be noted, though, that three-quarters of the 50,000 CHCD eligible recipients in the state are now matched with physicians who have agreed to be their principal care givers. In addition, these primary physicians have agreed to be responsible for ensuring recipients' access to appropriate specialists for any additional tests or treatments which are needed.

In Utah's most recent submittal of information to HCFA for waiver renewal (June, 1986), it was reported that, in early 1982, 229 physicians responding to a DHCF survey indicated their willingness to participate as case managers. As of April, 1986, there were about 1071 primary care physicians actively serving CHCD enrollees (616 operating individually and about 455 working in clinics).

In addition, there were physicians in two HMOs providing case managed care. These figures were reported as indicating a substantial increase in physician participation, at least since 1982, and, therefore, improved access. Without data on the number of physicians in Medicaid before CHCD, however, these data are inconclusive.

The DHCF also estimated that, for the year ended June 30, 1985, there were about 26 CHCD enrollees per provider. It was suggested that this ratio was well below the acceptable standards used by the Public Health Service.

It is significant that Utah Issues, the recipient advocacy group, still supports CHCD and even encourages its expansion state-wide to include Utah's rural areas. Presumably, this support would not continue if recipients were having serious problems with the CHCD system.

6.2 BETTER MANAGE RECIPIENTS' USE OF MEDICAL SERVICES

In addition to providing better continuity of care for recipients, primary physicians are also expected to reduce the inappropriate use of medical services. Problems such as doctor shopping and duplicative services should be reduced or eliminated by CHCD "gatekeepers". While DHCF established no specific utilization goals for CHCD, data from the first several years of operation indicate a reduction in several categories.

Figures from Salt Lake County for the first quarter (January - March) of 1982 and the first quarter of 1983, that is, for pre- and post-CHCD implementation, show reductions in the number of physician office visits, number of emergency room claims, number of pharmacy claims, and number of different physicians seen by recipients (see Exhibit 6.1 below). Utah reports there were no other factors or programs implemented during this period which could account for these decreases.

EXHIBIT 6.1

Specific Statistical Data, Average Per Client
Salt Lake County Case Management

Category of Claim	First Quarter 1982	First Quarter 1983	% Change
Number of Physician Office Visits	2.83	2.23	(21%)
Number of ER Claims	.29	.20	(37%)
Pharmacy Claims	4.28	3.77	(12%)
Number of Different Physicians	1.47	1.10	(25%)

Data Source: Supplement to Waiver Extension Request, April 13, 1984.

While encouraging, these data are insufficient for fully evaluating the impact of CHCD. DHCF can report, on a state-wide and county basis, overall utilization statistics on a variety of important measures, and these reports do show overall changes in the Medicaid program since the introduction of CHCD. While the SURS does identify specific recipients who are overutilizing services beyond acceptable limits, Utah's Medicaid Management Information System (MMIS) cannot provide such basic evaluative data as utilization patterns among recipients with the same CHCD physician and recipient-by-recipient utilization patterns before and after the introduction of CHCD.

Being a small state, Utah has historically preferred to handle problems with physicians on a personal, rather than system-wide, basis, however. DHCF has worked hard not to alienate physicians either individually or as a group. For example, DHCF has no provisions for second opinions or assessing the physician as financial manager.

Utah does conduct an annual "Exceptions Profile" in accordance with federal regulations. In this process, the MMIS selects ten physicians whose utilization patterns are exceptionally high. DHCF then carefully reviews the claims history of these ten providers to find reasons for the unusually high utilization rates. If the rates cannot be explained, administrative steps are taken. To our knowledge, no case managing primary care physicians have been identified as having exceptionally high utilization patterns.

Finally, since implementation of the CHCD, Utah has installed a general automatic edit function into the Medicaid claims processing system. This edit flags some inappropriate claims and triggers a letter to the physician. For a while, DHCF continued to pay the claim but warned that similar claims could be rejected in the future. After this transitional period of educating physicians, DHCF has started to suspend claims reimbursement on a routine basis.

6.3 CONTAIN COSTS IN MEDICAID WHILE PAYING EQUITABLE FEES TO PHYSICIANS

A. Early Data from Salt Lake County

Not surprisingly, the lower utilization rates in Salt Lake County led to lower Medicaid expenditures following the introduction of CHCD (see Exhibit 6.2 below). In the first quarter of 1982, Utah paid over $3.3 million (adjusted) in Medicaid claims for recipients enrolled with a primary physician in Salt Lake County. During the same period in 1983, claims dropped to $3.2 million, for a savings of $105,800 for that quarter, and an estimated $423,200 for the year. This averages out to about $32 savings per recipient per year.

Projecting these figures to the 29,000 clients enrolled with a CHCD primary care case manager in 1983 yields an estimated annual savings of $928,000 for recipients with primary physicians. Adding an estimated $670,000 savings from FHP, and subtracting an estimated $300,000 for CHCD administration, a total annual 1983 savings from CHCD, was estimated at almost $1.3 million. Utah expected this level of savings to continue, particularly if additional HMOs became available in other parts of the state.

Exhibit 6.2

Potential CHCD Savings Statewide
(45,429 Eligible Clients) $1,453,728,000

Although the statistics are quarterly, the data are compared over a year's time. Thus the full 8.88 percent inflation rate is used instead of the 2.22 percent Quarterly rate.

Actual Number of Clients Enrolled in Case Management in Utah, Davis, Weber and Salt Lake Counties.....	29,000
Dollars Saved/Client/Year..... x	$32
Estimated Total Savings Per Year in Case Management.....	$928,000
Estimated FHP Savings Per Year.....	643,198
Total Gross Savings FHP/Case Management.....	$1,571,198
Less Administrative Costs Including 10 Full Time Case Management Reps, 50 percent of one Secretary and 20 percent of two Administrators' Time.....	-296,555
Estimated Total Net Savings of "Choice of Health Care" in Utah.....	$1,274,643
Divided by Administrative Expenses.....	296,555

Equals $4.3 returned for every $1 invested.

Source: Waiver extension request, January 23, 1984

B. More Recent Data

In a July, 1986, supplement to the most recent waiver extension request, DHCF provided data on SFY 1984 and 1985 expenditures for recipients in the case management and HMO components of the CHCD program and for recipients in the fee-for-service program. Exhibit 6.3 presents the composite weighted total average monthly expenditures for the three groups of recipients. The figures are composites for the AFDC, Aged, Blind, Disabled and Medically Needy Children

Exhibit 6.3
Medicaid Expenditures: CHCD vs. Standard Program

Fiscal Year Ended June 30,	CHCD		Standard Fee-for-Service
	Case Management	HMOs	
1985			
Expenditures per eligible month	$ 81.59	$84.29	$ 84.90
Dollar savings over standard fee-for-service	3.31	.61	
Percentage of savings over standard fee-for-service	4.1%	0.7%	
1984			
Expenditures per eligible month	$ 70.27	$75.96	$ 78.56
Dollar savings over standard fee-for-service	8.29	2.60	
percentage of savings over standard fee-for-service	11.8%	3.4%	

Source: Division of Health Care Financing, "Supplement No. 2 to the Application for Continuation of Waivers (Dated December 30, 1985) Under Section 1915 of the Social Security Act," July 31, 1986.

recipient sub-groups in each of the three groups. They are weighted according to the percentage of total enrollee months that each sub-group accounted for during the year. The figures are for all recipients statewide, except for long-term care residents, who were excluded from the analysis since they are not eligible for CHCD.

The expenditure data in Exhibit 6.3 also take administrative costs into account. It was estimated that administration of the HMO component cost 7.4 percent on top of program costs, while case management administration cost 9.5 per-

cent and standard Medicaid cost 9.3 percent.

As Exhibit 6.3 shows, CHCD appears to have saved money in both the case management and the HMO components. At the end of SFY 1985, there were about 13,500 HMO enrollees and about 23,500 case management enrollees. Assuming the maximum of twelve eligible months for each enrollee, Utah may have saved as much as $98,800 through the HMO component and $933,420 through case management in 1985.

Exhibit 6.4 presents similar expenditure and savings data for each category of Medicaid recipient. While HMOs and case management appear to save money when all recipients are taken together as a group (total Composite figures), there are exceptions among the specific eligibility groups. In 1985, the CHCD actually lost money on AFDC recipients and medically needy children in HMOs, and aged recipients in case management. In 1984, AFDC and blind recipients had higher expenditures in HMOs than in the standard program; and aged and blind recipients had higher expenditures in case management than in the standard program.

C. Projected Savings for the Future

In the most recent waiver extension request, DHCF projected the savings that could be expected from the CHCD in SFY 1987 and SFY 1988. Factored into the projections were an expected expansion into rural areas, increased HMO contracting, an expected 3 percent annual increase in Medicaid eligibles in the CHCD, projected increases in fee-for-service and HMO rates, and the financing costs associated with advance payments under a capitated system. The figures also take into account projected CHCD administrative expenses of $643,550 for SFY 1987 and $722,075 for SFY 1988.

According to DHCF's projections, the CHCD will save $3.9 million in SFY 1986 and $6.3 million in SFY 1987. These figures represent savings of 7.0 percent and 10.4 percent, respectively, over the standard Medicaid fee-for-service program.

Exhibit 6.4

Medicaid Expenditures: CHCD vs. Standard Medicaid Program, By Recipient Group

Fiscal Year Ended June 30,	Aid Category					
	AFDC	Aged	Blind	Disabled	Medically Needy Children	Total Composite
1985						
Case Management						
o Expenditures per eligible month	$66.07	$99.83	$211.38	$225.22	$59.50	$81.59
o Dollar savings (loss) over standard Medicaid	$2.52	($11.66)	$54.85	$17.25	$6.82	$3.31
o Percentage savings (loss) over Standard Medicaid	3.7%	(13.2%)	20.6%	7.1%	10.3%	3.9%
HMO						
o Expenditures per eligible month	$72.00	$83.10	$122.55	$206.73	$69.99	$84.29
o Dollar savings (loss) over standard Medicaid	($3.41)	$5.07	$143.68	$35.74	($3.67)	$.61
o Percentage savings (loss) over Standard Medicaid	(5.0%)	5.8%	54.0%	14.7%	(5.5%)	0.7%
Standard Medicaid						
o Expenditures per eligible month	$68.59	$88.17	$266.23	$242.47	$66.32	$84.90
1984						
Case Management						
o Expenditures per eligible month	$56.71	$93.57	$115.94	$193.34	$74.23	$70.27

o Dollar savings (loss) over Standard Medicaid	$7.06	($12.23)	($29.18)	$40.81	$5.74	$8.29
o Percentage savings (loss) over Standard Medicaid	11.1%	(15.0%)	(33.6%)	17.4%	7.2%	10.6%
HMO						
o Expenditures per eligible month	$66.26	$77.30	$112.75	$188.41	$65.95	$75.97
o Dollar savings (loss) over Standard Medicaid	($2.49)	$4.04	($25.99)	$45.74	$14.02	$2.59
o Percentage savings (loss) over Standard Medicaid	(3.9%)	5.0%	(30.0%)	19.5%	17.5%	3.3%
Standard Medicaid	$63.77	$81.34	$86.76	$234.15	$79.97	$78.56

Source: Division of Health Care Financing, "Supplement No. 2 to the Application for Continuation of Waivers (Dated December 30, 1985) Under Section 1915 of the Social Security Act," July 31, 1986.

These projections reflect a very marked shift of non-CHCD recipients into CHCD and of CHCD enrollees from case management to HMO membership and increased per capita HMO savings during the two years. Among an estimated 45,387 CHCD eligibles in July, 1986, 13,400 (30%) were in HMOs, 19,295 (43%) were in case management, and 12,692 (28%) were in non-managed health care. In June, 1988, among an estimated 48,275 eligibles, 41,000 (85%) are expected to be in HMOs, 4,375 (9%) in case management, and 2,900 (6%) in non-managed health care.

As we have stated earlier, DHCF has been very aggressive in pursuing increased HMO participation in CHCD and increased enrollment of Medicaid recipients in HMOs. The most serious hurdle is simply the lack of HMOs in the rural areas of the state. In late 1986, there were three HMOs in the CHCD -- two staff models and one IPA -- and more were expected to join during the next year. Given that two of the HMOs were staff models, it is likely that many Medicaid recipients were actually changing providers under CHCD. In the case of the IPA model HMO, however, this would not necessarily be the case. It could be more a case of Medicaid physicians joining the IPA to maintain their caseload.

Data were unavailable to clarify the extent of actual turnover (or dislocation) in physician-patient relationships under CHCD.

As with Utah's analysis of CHCD's impact on utilization, the data and findings on savings reported here are limited by the methodology used to generate them. To our knowledge, DHCF has never tracked CHCD impact at the individual recipient level, only at the level of gross changes among the CHCD population over time. While DHCF believes that the reported reductions in utilization and expenditures are attributable to CHCD, other factors cannot be conclusively ruled out.

In another study under the Medicaid Program Evaluation, a team of researchers at Syracuse University conducted a detailed econometric analysis of Medicaid claims data for December 1983 to test the effects of case management on service use and expenditures.(2) Very briefly, the analysis established two groups of recipients, a treatment group of case managed recipients and a comparison group of those who were not case managed. Differences between the two groups, in terms of age, sex, race, county of residence and recent prior use of services were statistically controlled.

To test for the effects of case management, the two groups were compared with respect to the number of recipients using a service and the average dollar amount of service used, for six services. It was found that case management affects the probability of service use differently than it does the level of use among users. Case managed recipients, had a higher probability of using primary care physician services than non-case managed (as would be expected under case management); but, contrary to expectation, case managed recipients also had significantly higher rates of use for hospital outpatient department (OPD)/emergency room (ER), prescription drug, clinic-based physician and hospital-based physician services.

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2. Stephen H. Long and Russel F. Settle, Exploring Utilization and Expenditure Effects: Utah's Choice of Health Care Delivery Program (draft), Medicaid Program Evaluation Working Paper 4.6, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, January, 1987.

As for the level of use among users--that is, the dollar total of paid claims per user for the one-month period--there were few differences between the case managed and the non-case managed groups of recipients. The exception was significantly lower claims for hospital ER/OPD services among case managed recipients. Because the increase in the probability of using services is greater than the decrease in the claims amount per recipient, the total cost per recipient month is estimated to be about one quarter higher under case management.

These findings are in sharp contrast to the latest findings of Utah Medicaid. It should be noted here, however, that the Syracuse University analysis was based on one month's claims data, perhaps too limited a sampling of utilization patterns and levels. More importantly, the analysis only included recipients who had used services before and after the analysis period (i.e., it did not include all Medicaid enrollees); and care was taken to limit the analysis as much as possible to recipients who had likely been continuously enrolled in Medicaid for several months prior to the analysis month. (This may have biased the results, since, in another state's case management program it was found that case management was dramatically more effective with the non-continuously enrolled recipients than the continuously enrolled. Therefore, it is not clear how generalizable the Syracuse University findings are to the entire Utah Medicaid population.) At this point, given the methodological differences between the analyses conducted to date and the lack of any conclusive means of assessing the relative accuracy of each, the question of case management's impact on utilization and expenditures remains an open one.

6.4 CONCLUSION

The current understanding of the impact of CHCD can be summarized as follows:

- Those involved believe it is improving access and the management of care as well as yielding savings.
- Their belief in savings is supported by the Medicaid program's analyses, but the analyses are weak methodologically.
- The savings belief is refuted by a very recent econometric analysis of claims, but that analysis is also problematic.

Given this set of circumstances, states considering a fee-for-service model PCCM like Utah's should be cautious in defining expected impact, especially savings. The fee-for-service model is suspect because there are no obvious financial incentives for physicians to better manage care, not even a case management fee, as in other fee-for-service PCCMs. Why would a primary care physician -- the pivotal player in the CHCD - exert more energy to better manage care if there is no financial risk or opportunity?

On the other hand, those endorsing the model point to its utilization control aspects; namely the increased opportunity to better manage care because most non-emergency services must be provided, or approved, by a single case manager physician. Further, they suggest that the case manager role appeals to physicians because it matches the way they manage non-Medicaid primary care. In short, physicians will manage primary care well if given the opportunity through such mechanisms as being designated case manager for an individual Medicaid enrollee.

Considering the positive views of those involved in CHCD and the lack of definitive evidence that CHCD is not cost-effective, states considering a fee-for-service PCCM like Utah's should not be discouraged; especially if developing a financial risk sharing PCCM is untenable. The fee-for-service model does provide an intermediate model of managed care: more structured and controlled than open fee-for-service, but ostensibly less stringent than financial risk sharing models.

ATTACHMENTS

ATTACHMENT 1.1

"CASE MANAGEMENT PRIMARY PHYSICIANS"
(BROCHURE FROM THE UTAH DEPARTMENT OF HEALTH)

Case Management Primary Physician

UTAH DEPARTMENT OF HEALTH

This program was developed in cooperation with the UTAH STATE MEDICAL ASSOCIATION

PURPOSE

Case Management was developed by the State Department of Health, Division of Health Care Financing (DHFC) in response to the Omnibus Act of 1981. TO:

- provide recipient access to mainstream medical care,
- better manage recipient use of medical services, and
- contain costs in Medicaid while paying equitable fees to physicians.

Under the Plan, the recipient's medical care will be authorized or arranged for by a primary physician, thus guaranteeing the physician/patient relationship.

PRIMARY PHYSICIAN

Generally, a primary physician will be a practitioner whose practice is in the field of general practice, family practice, pediatrics, internal medicine or obstetrics/gynecology. When a specialist (e.g., OB/GYN) becomes a primary physician, he/she will then render primary care to recipients for colds, flu, etc. The physician may have an individual practice or an outpatient hospital practice, which has agreed to be reimbursed on a fee-for-service basis.

When physicians in a clinic setting are primary physicians, a recipient may be referred and be seen by alternate physicians; but the recipient's chart and billing would serve to indicate whether duplicate or unnecessary services would result. If a physician wishing to be a primary physician is not currently a participating Medicaid provider, he/she would also have to enroll in the Medicaid program.

ELIGIBLE MEDICAID RECIPIENT

Most Medicaid recipients qualify for the Plan. A recipient will **NOT** be assigned a primary physician if he/she is currently:

- residing in a long-term-care facility,
- enrolled in a health maintenance organization (HMO), such as FHP,
- a Lock-in client,
- a Group II recipient with an end date of Medicaid eligibility (e.g., the recipient will be eligible for Medicaid for a short time due to a major illness),
- in protective custody, or
- a client on Medicaid for 30 days only.

The Primary Physician Case Management Plan does not apply to the Crippled Children or General Assistance (GA).

Recipients excluded from the Plan will continue to receive Medicaid-covered services from the providers they choose. As a primary physician, you may also continue to provide services to these recipients.

PHYSICIAN—RECIPIENT MATCH

If you are already participating in the Medicaid program and sign the application attached to this brochure to become a primary physician, DHCF will generate quarterly a list of all the Medicaid recipients that you have seen.

For each new patient under your Case Management care DHCF will send you a letter explaining the Plan and thanking you for being his/her primary physician. Your name will be printed on the Medicaid ID Card as the recipient's primary physician.

If a recipient is eligible for the Case Management Plan but does not know a doctor:

- The recipient may select to continue with his/her current physician, if the physician is participating in the Plan.
- The recipient may choose a physician from a list of physicians participating in the Plan.

NOTE: Your name will be placed on the list if you indicate on the application that you are willing to take additional Medicaid recipients under the Plan. If you currently do not have any Medicaid recipients, you must indicate on the application that you will accept new Medicaid recipients in order for your name to be placed on the primary physician list.

- The recipient may enroll in an HMO, in which case all family members must enroll in the HMO.

  NOTE: **Except for HMO** recipients, family members may choose the same primary physician or choose different primary physicians (e.g., a pediatrician for a child and a different physician for the adults in the family).

When a person first becomes eligible for Medicaid, the local case worker will present the options discussed above.

CHANGE AN ASSIGNMENT

A physician or a recipient wishing to terminate the physician-recipient relationship may do so upon reasonable notice and for a justifiable cause. You will be instructed who to contact to initiate such action. When a recipient is removed from one primary physician he/she must select another.

PROVIDING MEDICAL CARE

As a primary physician, you continue to provide and arrange Medicaid-covered services for the recipients under your care. You prescribe treatment (e.g., prescriptions, laboratory and radiology tests, medical equipment and hospitalization) whenever medically necessary. You must be available or have appropriate coverage for your Medicaid recipients on a 24-hour basis just like you always do for your private patients.

REFERRING MEDICAL CARE

You may refer the recipient to another physician for specialty care using the "Physician Referral Form". The physician to whom the recipient has been referred can order laboratory and radiology tests and prescriptions without your authorization; however, you must be notified when the recipient is admitted into the hospital. The primary physician will authorize the referral care for the duration of the recipient's illness. If the recipient has a chronic condition which requires ongoing specialty care, the authorization will cover a longer period.

You will be informed by DHCF of all the services which were provided to the recipient, including those services which were provided as a result of the referral. This report will serve as an informational/educational vehicle for you to further evaluate the services received by the recipient.

NOTE: A specialist who is not a primary physician may continue to treat Medicaid recipients who are referred from their primary physicians.

EMERGENCY MEDICAL CARE

The recipient will be instructed to call your office first in any emergency situation to determine if he/she can be treated in your office. If you cannot treat the recipient in your office, you may authorize emergency treatment elsewhere. However, another provider may provide emergency treatment without your authorization, for any condition for which delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health. Once the emergency no longer exists, your authorization is required for non-emergency care.

BILLING

As a primary physician, you bill DHCF on a fee-for-service basis for the Medicaid-covered services that you provide. Billing procedures are explained in the Medicaid Physician Provider Manual. However, in order to provide timely information to DHCF for management reports, claims should be submitted within 12 months from the date of service. Six months should allow sufficient time to bill other resources (e.g., health insurance, auto insurance, etc.).

SPECIAL NOTE: It is imperative that you inform the following providers of your Physician License Number when you authorize them to provide services to a recipient under your primary care:

- another physician (including radiologist, anesthesiologist, etc.) or
- a hospital provider.

These providers must enter your Physician License Number as the referring physician on their Medicaid claim.

As a primary physician, regardless of your provider type, you will be reimbursed on a fee-for-service basis for Medicaid-covered services.

Please seriously consider becoming a primary physician. Your participation is needed to make the Plan a success. The Plan guarantees you the continuity of a physician/patient relationship with the Medicaid recipients whom you serve.

NOTE: Always review the recipient's Medicaid ID Card to insure he/she is eligible and to determine if there is other insurance coverage that can be billed for the care that you are providing.

APPLICATION INSTRUCTIONS

The application must be completed by the individual physician (i.e., each physician in a clinic or group practice) for the location indicated on the application card. If you practice in more than one location, you must complete an application for each location where you wish to be a primary physician.

After you complete the application, return it to DHCF. For your convenience, the address has been printed on the card.

PAYMENT

Payment will be generated on a fee-for-service basis at the same rate as in the other Medicaid Programs. Any savings generated by the Case Management Program will be shared at the end of the year between DHFC and the primary physicians participating.

QUESTIONS

If you have any questions about Case Management or if you need additional information, please call the Medicaid Bureau of Provider and Client Services at 533-6571 or 1-800-662-9651.

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY CARD

FIRST CLASS PERMIT NO. 6279 SALT LAKE CITY, UTAH

POSTAGE WILL BE PAID BY ADDRESSEE

Case Management Program
Utah State Department of Health
Division of Health Care Financing
P.O. Box 510167
Salt Lake City, UT 84110

PRIMARY PHYSICIAN PLAN APPLICATION

As a primary physician you will be placed on a Provider list. Recipients may select you from this list. This application is for your practice location indicated on the card. Please verify your name and address and answer the following questions:

LABEL

1. Will you accept new Medicaid patients under Case Management?
   yes☐ no☐
2. Will you accept your current Medicaid patients under Case Management?
   yes☐ no☐
3. Do you have a practice specialty?

   Please specify _____
4. Specify the name of the clinic or group practice for this location if appropriate

   _____
5. The telephone number for this location is

   _____

ATTACHMENT 1.2

"CASE MANAGEMENT" (INFORMATION SHEET FOR PRIMARY CARE CASE MANAGERS)

CASE MANAGEMENT

You will be the only primary physician this client has. You will act as a "gatekeeper" for his/her medical management. This system has benefits for both client and physician, while being more cost effective for Medicaid.

I. Management of Medical Care for One Client

- The primary provider will be the only one to order laboratory and x-ray studies. This should reduce duplication of services and should serve to enhance quality of care.
- The primary provider will be the only one to prescribe medications (except for specialists designated by you). This should help to prevent incompatibility of drugs that often occurs when clients "doctor-shop." As well, it provides you with complete knowledge of the patient's medications.
- The primary provider will be the principle provider managing the health care of the patient. This should promote a greater level of understanding on the part of the patient and reduce confusion that so often results in haphazard and wasteful use of health care resources.

II. Communication and Interaction Between You and the Client

- The opportunity exists to establish a true, productive doctor-patient relationship.
- Time should be saved through more efficient diagnosis and treatment because of improved knowledge of the patient.
- Greater compliance with diagnostic and therapeutic strategies should be achievable through a trusting relationship between physician and patient.

- The opportunity to change client behavior should exist through patient education.

III. Emergency Care

- Clients will be instructed to, in the event of an emergency, contact their primary physician first.
- Because the primary physician knows the client he/she can best determine the location at which care should be given--either in the emergency room or in the physician's office. This should help to avoid unnecessary and inappropriate use of the emergency room. This should also help to reduce the number of duplicated x-rays and laboratory tests that so often occur in non-coordinated care.

IV. Specialist Care

- If a client needs specialist care, you, as the primary physician, should refer him/her using a referral form specifically designed to facilitate information exchange. Your communication and interaction with the specialist should ensure entry to the specialist and knowledge on the part of the specialist of pertinent previous care, including laboratory data, x-ray results, and medication history.
- In this program the client will be authorized to go only to the specialists to whom you send him/her. In this way, medical necessity will be stressed and communication should be enhanced.

V. Termination of the Agreement

- Removal of a client may occur in a number of ways:
  1) If the client becomes ineligible for Medicaid.
  2) If the client states in writing to the central Medicaid office his/her reason for changing providers (moving from area, personal

differences with provider, etc.).

3) If you, as the primary provider, wish to terminate from the case, either because of personal reasons or because you feel the client can be better handled by some other type of physician. To do this, you would contact the Department of Health, Office of Health Care Financing at 533-5031 (in Salt Lake County) or 1-800-662-1796 (in all other areas).

If you have questions or concerns regarding this program, contact Carol Thomas at the above phone number. We hope to work with you in all ways to ensure the success of this program.

/kn

11/25/81

ATTACHMENT 2.1

PHYSICIAN REFERRAL FORM

Utah-SDH-DHCF
Form 1.6 9/82

FORM NUMBER
24 06 55

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

PHYSICIAN REFERRAL FORM

DIVISION OF HEALTH CARE FINANCING
CLIENT UTILIZATION CONTROL PROGRAM

MAIL TO:
Client Utilization Control Program
Room 440
P.O. Box 510167
Salt Lake City, Utah 84151

The recipient named below requires medical services in addition to those that I provide. I am, therefore, referring the recipient to the practitioner named below, as discussed with the recipient.

RECIPIENT NAME _____ _____ _____
Last First Middle

MEDICAID ID NUMBER: _____

CONSULTANT REFERRED TO: _____
Practitioner Name (Please Print)

_____
Address (Please Print)

REASON(S) FOR REFERRAL:

- ☐ Opinion Only
- ☐ Concurrent Care
- ☐ Referred for Assumption of Care

DIAGNOSIS (ES) and/or CONCERNS:

Referring Provider Name, Address and Telephone	
* Referring Provider License No.	Date Referral Authorized

***NOTE: TO CONSULTANT**
To assure prompt payment when billing for your services, assure that the Referring Physician License Number is entered in the "Referring Provider License Number" field on your HCFA-1500 or Inpatient Hospital Invoice. See Attachment E of your Medicaid Provider Manual.

_____
Referring Provider Signature

One copy for Client Utilization Control Program
One copy for Recipient
One copy for Referring Physician

ATTACHMENT 2.2

CHOICE OF HEALTH CARE DELIVERY ENROLLMENT FORM

[redacted]

CHOICE OF HEALTH CARE DELIVERY

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

Form Number 24 08 56

Invoice No. № 0024100

HEALTH MAINTENANCE ORGANIZATION ☐

Date Previously Enrolled in HMO (MM DD YY) | Date Terminated HMO (MM DD YY) | Never Enrolled (N) | New Start Date (MM DD YY)

INDEPENDENT PRACTICE ASSOCIATION ☐

Date Previously Enrolled in IPA (MM DD YY) | Date Terminated IPA (MM DD YY) | Never Enrolled (N) | New Start Date (MM DD YY)

CASE MANAGEMENT ☐

Date Previously Enrolled in CM (MM DD YY) | Date Terminated CM (MM DD YY) | Never Enrolled (N) | New Start Date (MM DD YY)

2. Client ID Number

3. Last Name | First | MI

4. Telephone Number

12. Street Address | City | State | Zip

Primary Provider/Physician

5. Last Name | First | MI

6. Provider ID No.

7. Telephone No.

8. Street Address | City | State | Zip

Children Information:

13. Child's Name	16. Child's ID Number	17. Repeat	14. Provider's Name	18. Provider ID Number	15. Provider's Address and Telephone
Child's Name	Child's ID Number	Repeat	Provider's Name	Provider ID Number	Provider's Address and Telephone
Child's Name	Child's ID Number	Repeat	Provider's Name	Provider ID Number	Provider's Address and Telephone
Child's Name	Child's ID Number	Repeat	Provider's Name	Provider ID Number	Provider's Address and Telephone

I agree to the above choice and I understand the information presented.

Client's Signature _____

Date _____

19. Date Physician Letter Sent (MM DD YY)

SDH-DHCP (1/9) 5/82

ATTACHMENT 2.3

CHANGE OF PROVIDER AND DISENROLLMENT FORMS

FHP HEALTH CARE CHANGE FORM

SAMPLE / SAMPLE

Planned date of change

Client's Last Name | First Name | Initial | Social Security No. — —

Street Address | City | State Utah | Zip

Telephone Number | Message Number

Please check health care preference:

☐ Health Maintenance Organization (FHP)
☑ Case Management

I understand that I am enrolling all my eligible family members in this program.

Signature of Client | Date | FHP Representative

Social Security No.	Name of family members to be added or deleted (circle one)	Relationship	Birthdate Mo.	Day	Yr.	Sex

61F014

FHP

SAMPLE / SAMPLE

REQUEST FOR DISENROLLMENT

Head of Household 1st Last Name	First, Middle	Sex	Birthdate Mo. | Day | Yr.	SS # or Case #	FHP #

For more than seven line items, attach additional forms.

Reasons for Disenrollment:

Mandatory Disenrollment ☐

Disenrollment for Cause (Within contract period) ☐

Voluntary Disenrollment ☐
30 Day 1 year

Disenrollment requested by:

Beneficiaries named above ☐

The Health Plan ☐

Medicaid Information Office ☐

Enrolled by _____ Date _____ Certified Date _____

IT IS UNDERSTOOD THAT DISENROLLMENT IS SUBJECT TO APPROVAL BY THE DEPARTMENT OF HEALTH. I ALSO UNDERSTAND THAT I AM NOT DISENROLLED FROM FHP / UTAH UNTIL THE DISENROLLMENT IS APPROVED. I WILL CONTINUE TO OBTAIN MY MEDICAL SERVICES FROM FHP UNTIL I RECEIVE MY REGULAR MEDICAID CARD. I ALSO UNDERSTAND THAT IF THIS REQUEST IS APPROVED BY FHP, I MUST TAKE A COPY OF THIS FORM TO THE DEPARMENT OF HEALTH WORKER IN MY DISTRICT.

Reason for disenrollment

If Approved, planned disenrollment date _____

FHP has approved this request subject to the approval of the Utah State Department of Health.

The Utah State Department of Health hereby

☐ Approves ☐ Disapproves Authorized Signature: _____

Copies must be returned to FHP for processing (Please type name below signature)

x _____ Signature of Enrollee or Guardian Phone Date

x _____ Signature of Authorized Personnel Date

Original: MRS Yellow: Department of Health Pink: Health Plan Goldenrod: Medicaid Member 60F005

ATTACHMENT 2.4

"MEDICAL REVIEW PROGRAM FOR MANAGED
HEALTH CARE SYSTEMS"

March 14, 1986
3961U

Bureau of Medical Review
Medical Review Program for Managed Health Systems

NEED:

In order to ensure the quality and accessibility of managed health care to Medicaid recipients, it is necessary to develop a comprehensive medical review program.

OBJECTIVES:

The objectives of this program are:

1. To develop, promulgate, and monitor compliance with standards of quality of care rendered by managed health systems, and

2. To monitor the appropriateness of enrollment and disenrollment during the process of medical review. Details of abuse findings will be forwarded to the Bureau of Managed Health Services.

METHODS:

The Bureau of Medical Review will:

1. Develop and recommend quality standards [42 CFR 434.52 (b)] (e.g. the current JCAH Ambulatory Health Care Standards or the State of Pennsylvania Rules and Regulations) be adopted by:

   a. Contractual agreement.

   b. State rulemaking.

2. Implement a system of periodic medical reviews [42 CFR 434.53] that:

   a. Are conducted at least once a year for each contractor;

   b. Are based on management data supplied by each contractor and used by Bureau medical review personnel;

   c. Focus on a sample of recipients selected by analyzing the management data supplied by the contractor for specific indicators which are listed in attachment A. Initial sample size will be 1% of the total Medicaid enrollment per year with a projected target goal of at least 3%.

   d. Include a complete evaluation of the medical record for each recipient in the selected sample. In each case reviewed, specific attention will be placed on whether the contracted services were appropriate using the following four-point model:

c) Mock reports will be written and submitted to Division Director by June 20, 1986.

d) Corrective Action Plans will be obtained from the contractor when and if appropriate.

e) Follow up visits will be made to ascertain timely and appropriate correction of identified problem areas cited.

b. The Bureau of Medical Review will work closely with the Bureau of Managed Health Systems to establish a referral system for the purpose of forwarding abuse findings concerning enrollment and disenrollment.

PURPOSE:

The purpose of the quality assurance program for MHS's is to:

1. Ensure quality of care rendered to Medicaid recipients of managed health systems.

2. Determine the availability and appropriateness of services provided to Medicaid members by a variety of health care professionals (an interdisciplinary health care team).

3. Monitor the adequacy, effectiveness, appropriateness and efficiency of health care delivered to Medicaid members using MHS services.

4. Monitor all aspects of health care services ie., outpatient services, emergency services, and inpatient hospitalization(s) of Medicaid members.

5. Assure that the health and safety of Medicaid members is being protected through MHS compliance with certain minimum standards for facilities.

Medical Review Methods:

1. Review and evaluation of medical records to determine appropriateness of care given by medical providers (ie, physicians, osteopaths, physician assistants, certified nurse midwives, and nurse practitioners).

2. Determine awareness of areas of non-compliance, material deficiencies or problem areas which are inconsistent with professional standards for high quality care.

1). Severity of illness -- the degree of loss of health based on subjective report, signs, symptoms, diagnostic test results, and provider assessment and diagnosis.

2). Intensity of service -- the amount, duration, and scope of medical intervention necessary and ordered to obtain a more favorable level of health or to prevent deterioration.

3). Care setting -- the actual physical/clinical location, the available care programs, the available professional staff, the available non-professional persons and their level of training (includes family members).

4). Outcome -- the measurable, desired and actual results of the course of treatment described by observable indicators of improvement or maintenance of physical/mental functioning and health status.

e. Ensure quality and accessible health care to enrolled Medicaid recipients by:

1). Contractor compliance with defined quality standards; and

2). Contractor and licensed practitioners adherence to accepted professional practice standards;

3. Issue reports by medical review personnel of non-compliance with standards containing the observations, conclusions, and recommendations;

4. Require the contractor to submit a timely corrective action plan in response to report findings, including a date by which the correction will be completed;

5. Evaluate corrective plans submitted by contractor and monitor progress towards correction.

EVALUATION:

Evaluation of Bureau objectives and methods used in this medical review process shall be obtained through utilization of the following procedural steps outlined in the paragraphs below. If desired results are not being obtained according to anticipated schedule, then the objectives of the plan will be re-evaluated and the methods adjusted accordingly.

1. Testing of the Plan

The Bureau will evaluate the effectiveness of the plan by initially determining if the following benchmarks have been met:

a. The Bureau will receive a list of enrolled Medicaid patients with any occurrence of a diagnosis from Attachment A by April 11, 1986.

b. The medical review personnel will review a selected random sample of 5 patients by April 18, 1986.

c. Mock reports will be developed as though JCAH model standards or the State of Pennsylvania Rules and Regulations for quality care had been adopted by April 25, 1986.

2. Recommendation for Capitated Plan for Ambulatory Services RFP

a. Memo to Director of Health Care Financing recommending standards to be included in the Capitated Plan for Ambulatory Services RFP by May 1, 1986

b. Ascertain if the Division Director has an interest in performing regulatory enforcement.

c. If the Division does not have an interest in performing regulatory enforcement, advise Director of Health Care Financing that with present resources, it is recommended that promulgation of standards through State rulemaking should not be considered at this time.

d. It will be recommended that specific minimum data requirements be included in the Capitated Plan for Ambulatory Services RFP.

e. It will be recommended that the Capitated Plan for Ambulatory Services RFP include requirements for Bureau access of all contractor records.

3. Implementation of the Plan

a. Ascertain that objective #1 has been met by:

1) Bureau identification of standards of quality care

2) Promulgation of standards by:

a) Offering a Request for Proposals (RFP) leading to mutual contractual agreements, or

b) Development of Bureau standards in conjunction with the Bureau of Health Facility Licensure to be channeled through the State rulemaking process.

3) Bureau of Medical Review monitoring of contractor's compliance with standards of quality of care.

a) An onsite review will be made of each managed health system contractor prior to June 1, 1986.

b) Report of onsite review findings and recommendations will be made of each managed health system contractor prior to June 13, 1986.

ATTACHMENT 2.5

"QUALITY ASSURANCE PROGRAM: HEALTHWISE"

QUALITY ASSURANCE PROGRAM

HEALTHWISE

Quality Assurance is a central part of HealthWise's corporate philosophy. Appropriate utilization of resources and a safe patient environment are the goals of the review and evaluation of patient care and clinical performance.

In order to achieve proper utilization of resources and a safe patient environment, HealthWise collects information about the care and services provided for and received by members. Sources of data include:

- Referral authorizations (facility and specialist);
- Concurrent hospital and outpatient surgery review, including justification of treatment and outcome;
- Utilization review of outpatient services, including emergency room and office visits, laboratory, radiology, therapies, surgery and prescriptions;
- Grievances, inquiries, surveys and observations from patients and physicians;
- Retrospective claims audits

The objectives of monitoring patient care are:

- To routinely monitor provider and patient profiles
- To determine if care is necessary, and appropriate and cost efficient
- To identify patient care problems
- To focus upon the resolution of patient care problems through intensive investigation and appropriate action
- To follow-up on corrective actions to see if improvement has occured and is sustained
- To establish priorities for further study and action

Quality assurance is a function of the Medical Services Department. Members care is monitored to evaluate and make recommendations regarding adherence to the principles and practice of quality, cost effective medical treatment. Pertinent concerns and measures are taken to promote high standards and reported to the Quality Assurance Committee, a subcommittee of the HealthWise Board of Directors which meets at least quarterly.

employed by HealthWise.

1. Provider, Member and Facility Audits
Established MIS reports provide standards for utilization and quality assurance review. Specific audits are undertaken where trends on behavior indicates a significant deviation from the norm.

2. Peer Review
Peer review activities occur routinely and at several levels. These activities include monitoring of Utilization Management and Quality Assurance Programs, including preadmission, concurrent and restrospective reviews by the Medical Services Department, the participating Medical Groups, and the Quality Assurance Committee. The focus of these reviews is on:

a. Overutilization and underutilization of services which may affect member health status and/or cost

b. Physician profile reports

c. Patient feedback concerning physicians

d. Overutilization of health care services or facilities by patients

3. Inpatient Review
HealthWise performs concurrent review of emergency and elective inpatient admissions. Nurse Coordinators monitor the care of members in accordance with guidelines and criteria established by the Department, the Medical Director and the Affiliated Physicians Group Committee. Aspects of the monitoring process include:

a Appropriateness of the length of care

b. Hospital length of stay

c. Select auditing of patient charts

d. Discharge planning

The guidelines and criteria for inpatient review are compatible with the industry's established quality assurance and utilization review protocols.

4. Other Review
HealthWise monitors selected elements of care which are key indicators of quality. Reports are made available for management, Board committees, Medical groups and physicians to review.

Circumstances which suggest deviation from suggested standards include:

a. Patients with more than average number of office visits

c. Patients with an unusual number of visits to an emergency room

d. Utilization by type of service category

SUMMARY

HealthWise regards the quality assurance plan as a working document, an on-going responsibility.

Specific focus for reviews vary, depending upon identified concerns or preplanned areas for audit. The overall objective is to continually monitor and assure that quality care is being provided HealthWise members.

FORMAT FOR MEDICAL CARE EVALUATION STUDIES

Topic:

Objectives:

Methodology:

Problem(s) Identified:

Date Study Initiated:

Date Study Completed:

Results of Study:

Recommendations or Conclusions:

Action Taken:

Person(s) Responsible for Action:

Follow-up:

This is the current format I am using for MCE's. At the present time we are auditing readmissions during the 1st quarter of 1986, using this format. Data we are looking at is as follows:

- °HealthWise member months
- °Number of Discharges
- °Discharges/1000
- °Number of Readmissions
- °Readmissions/1000
- °Number of Readmissions secondary to a previous hospitalization

HEALTHWISE
EKG AUDIT (PROCEDURE CODES 93000-93014)
CLAIMS INCURRED 1985 - PAID THRU 2/25/86

INTERNAL MEDICINE PCP's*

Internist	Med Group	Member Months	# Pts. with/ at least 1 EKG	% Membership w/ at least 1 EKG	Total EKG Claims	% EKG's/ Membership
		4269	50	1.2%	50	1.2%
		3012	42	1.3%	47	1.6%
		1418	48	[redacted]	49	3.5%
		2293	38	2.6%	42	1.8%
		1090	35	3.2%	37	3.4%
		950	25	2.6%	28	2.9%
		681	30	[redacted]	35	4.1%
		1583	23	1.5%	26	1.6%
		888	21	[redacted]	23	2.6%
		1217	20	1.6%	21	1.7%
		901	20	[redacted]	25	2.8%
		1078	19	[redacted]	19	1.8%
				2.35% Avg.		2.5% Avg.

*Top 12 paid

This audit showed that internists in one medical group had a much higher percentage of EKG utilization than their peers. It was used as an educational tool for reevaluating the use and abuse of office diagnostic procedures.

[redacted] = same provider group

[redacted] = same provider

PROCEDURE CODE AUDIT - CPT CODES 95005 - 95199 (ALLERGY)

1984

PHYSICIAN	SPECIALTY	TOTAL CASES BY DOS	TOTAL MEMBERS TREATED	TOTAL BILLED	TOTAL PAID	AVERAGE AMOUNT BILLED PER MEMBER SERVED
[redacted]						95215
	Allergist	41	19	2,335.73	1,721.53	122.93
	ENT	95	32	1,962.00	1,494.65	61.31
	Allergist	19	16	1,429.40	1,108.23	89.34
	Allergist	14	15	1,145.90	972.03	76.39
	Allergist	10	8	1,109.25	811.25	138.66
	Allergist	9	5	924.74	613.00	184.95
	Allergist	6	5	795.00	644.49	159.00
	Allergist	14	6	545.60	282.58	90.93
	Gen. Practice	5	5	528.71	340.33	105.74

1985

[redacted]						95165
	Allergist	97	26	2,792.00	1,358.70	107.38
	ENT	88	34	2,768.00	1,185.37	81.41
	Allergist	102	19	2,684.00	1,387.47	141.26
	Allergist	57	22	2,239.00	1,165.11	101.77
	Allergist	32	14	1,410.00	889.36	100.71
	Allergist	28	11	1,260.00	839.17	114.55

PROCEDURE CODE AUDIT - CPT CODES 95005 - 95199 (ALLERGY)

1985 (cont.)

PHYSICIAN	SPECIALTY	TOTAL CASES BY DOS	TOTAL MEMBERS TREATED	TOTAL BILLED	TOTAL PAID	AVERAGE AMOUNT BI PER MEMBER SERVED
	Allergist	7	5	$1,138.75	$265.12	$ 227.75
	Allergist	59	8	1,069.50	582.50	133.69
	Family Pract.	10	9	767.28	587.70	85.25

This audit was the first screening process for a provider who appeared to overtreat allergic conditions. There has been concern for the quality of care, and we are expanding the audit to other conditions. Therefore, final documentation has not been completed at this time. A consulting allergist has been working with us to provide expertise. A survey of allergy treatment was conducted to add to documentation of the appropriateness of treatment (see attached).

This audit evolved from the allergy audit. It identified the inappropriate diagnosis of candidiasis. This is part of the continuing analysis of this provider's care.

HEALTHWISE

CANDIDIASIS AUDIT
1984 - 1985

1984 PHYSICIAN	SPECIALTY	MED GROUP	TOTAL CLAIMS	TOTAL PATIENTS	TOTAL BILLED	AVERAGE BILLED/PT	TOTAL PAID	AVERAGE PAID
[redacted]	GP		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	GP		7	6	411.94	68.65	270.88	45.14
	GP		5	5	338.00	67.60	230.60	46.12
	GP		6	6	293.65	48.94	226.16	37.69
	FP		2	2	141.00	70.50	117.10	58.55
	FP		4	4	145.00	36.25	116.25	29.06
	GP		1	1	164.00	164.00	114.04	114.04
	IM		3	2	141.50	70.75	99.90	49.95
	IM		2	2	141.00	70.50	89.41	44.70
			3	2	148.00	74.00	76.76	38.38

1985								
[redacted]	GP		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	IM		4	4	239.00	59.75	121.54	30.38
	OB		3	3	133.00	44.33	113.60	37.86
	FP		2	2	118.00	59.00	101.80	50.90
	FP		6	6	178.00	29.66	99.20	16.53
	GP		5	5	167.00	33.40	96.60	19.32
	OB		4	4	142.00	35.50	96.00	24.00
	OB		4	3	137.00	45.66	94.36	31.45
	FP		6	6	170.00	28.33	89.52	14.92
			4	4	115.00	28.75	80.00	20.00

HEALTHWISE
A FEDERALLY QUALIFIED
HEALTH MAINTENANCE
ORGANIZATION

Dear

HealthWise has been reviewing diagnosis, evaluation and therapy for allergy diagnoses. Please complete the attached questionnaire regarding your allergy protocol and treatments and return it to HealthWise by March 5, 1986. A self addressed, stamped envelope is enclosed for your convenience in replying.

Your attention to providing the information will be helpful in our evaluation of allergy services.

Sincerely,

Pam Wickstrom

Pamela C. Wickstrom, R.N.
Administrator
Medical Services

Attachment

PCW:js

2505 Parley's Way, P.O. Box 31804 • Salt Lake City, Utah 84131-0804 • (801) 487-4917
SPONSORED BY BLUE CROSS AND BLUE SHIELD OF UTAH

ALLERGY PROTOCOL AND TREATMENT

1. What type of testing is performed?

2. What type of antigens are used in the testing?

3. How many allergens are tested?

4. What types of therapy are prescribed or administered?

5. What is the frequency of the treatment?

Comments:

ATTACHMENT 2.6

"QUALITY ASSURANCE (UTILIZATION MANAGEMENT)
PROCEDURES FOR SERVICES PROVIDED BY HMO"
(FROM DHCF SAMPLE CONTRACT)

ATTACHMENT D

QUALITY ASSURANCE (UTILIZATION MANAGEMENT) PROCEDURES FOR SERVICES PROVIDED BY HMO

HMO shall establish a written plan for quality assurance and utilization management for all covered services, which shows evidence of a well-defined, organized program designed to improve client care. The plan must:

a. Show systematic surveillance and assessment of all modes of delivery by appropriate health professionals;

b. Show mechanisms and/or designation of individuals with specific responsibility to resolve identified problems;

c. Provide for monitoring to assure that resolution is achieved and maintained with documentary evidence of same;

d. Require use of written, clinically sound criteria to enhance client services and assure sound clinical performance by health care deliveries;

e. Result in identification of important client service problems or potential problems including utilization of service patterns by provider and recipient;

f. Monitor the effectiveness of the client grievance process; and

g. Be in accordance with the Code of Federal Regulations, Title 42, and the Utah State Title XIX Plan. Adherence to the points and conditions of Attachment D will assure compliance with this requirement unless modified by addendum to this attachment for specific services.

Prior to implementation, the final copy of the plan must be approved by the Division of Health Care Financing and will become a part of this contract.

In order to assess medical necessity, appropriateness, quality of care, and timeliness of service, the HMO must monitor services to all Medicaid enrollees in accordance with the written, approved plan.

Provision of high-quality health care services must be demonstrated by:

a. Adequate and appropriate diagnostic procedures;

b. Treatment necessary and relevant to the working diagnosis;

c. Appropriate consultation(s);

d. Patient compliance with treatment;

e. Continuity of care with adequate transfer of information between health care providers;

f. Appropriate, accurate, and complete client records;

g. Patient satisfaction ;

h. Accessibility and availability of services including emergency services;

i. Patient instruction in self-care, prevention and the use of medications and therapies.

j. The utilization of the least invasive and/or expensive resources when possible; and

k. The use of ancillary services consistent with patients' needs.

Objectives of Quality Assurance Monitoring

The objective of the quality assurance monitoring process is to ensure compliance to State and Federal policies, rules and regulations; and adherence to community standards; integrity of Medicaid payments made for medical services provided to eligible recipients under HMO. To achieve that objective procedures must:

a. Ensure that methods are in place which result in the identification of program abuse or suspected abusive or fraudulent behavior by either providers or recipients.

b. Ensure that appropriate, effective and coordinated action is taken on all such information.

c. Include a series of progressively more stringent administrative actions culminating in civil legal action to:
   1. Correct the behavior of providers or recipients violating program regulations as defined in the Enrollment Agreement or exhibiting inappropriate program utilization;

   2. Penalize providers or recipients who fail to correct aberrant practices and continue to abuse the program;

   3. Ensure that funds do not continue to be disbursed in the presence of evidence indicating such practices;

   4. Ensure that any funds improperly disbursed, as a result of such practices, are recovered.

ATTACHMENT 2.7

"CASE MANAGEMENT"
(BROCHURE FOR RECIPIENTS)

MEDICAID RECIPIENT

The Department of Social Services has qualified you for the Medicaid Program. It is your responsibility to see that you use this service carefully.

Your medical needs will be provided in one of two ways. You may choose the one you prefer for yourself and/or your eligible family members. The choices are as follows:

1. FHP
2. Case Management

There are brochures available which explain FHP.

The Case Management Program is a new program designed to identify a primary doctor for each member of your family if you wish. First, you may use your present doctor if he will consent to be on the program, or you may choose one from our list of available doctors. You must choose a doctor who is located in your area for convenient access.

Having a primary doctor who is responsible for your care will provide you with better medical services.

"Your doctor" will now supervise all of your medical needs. If he thinks you should see a "specialist" he will refer you to the one he chooses for your condition.

This contact between "your doctor" and the specialist will provide you with balanced care and careful review of your needs. Remember to call "your doctor" first in all cases even emergencies. If for some reason your doctor is not available, he will leave another doctor in charge of his patients.

If "your doctor" is not available and if he has not left anyone in charge of his patients, you may then see another physician if necessary. If you desire to change doctors before the 12 month period, you will be allowed to do so only **when you send a written notification to the Division of Health Care Financing** stating the reason you wish to change.

These are the acceptable reasons for changing doctors:

1. A change of physician may be requested when you or your doctor move and it is no longer easy for you to get to him.
2. A change of physician may be requested when you have had your primary doctor for 12 months and you wish to change to a different doctor
3. A change of physician may be requested if your medical needs **require** a change. A list of medical needs which could allow you to change doctors is available on request.
4. A change of physician may be requested when the change is for an **acceptable** personal reason. A list of acceptable personal reasons which should allow you to change doctors is available upon request.

All request for change of primary doctor must be reviewed by the Division of Health Care Financing and you must have another doctor who is willing to accept you as a client in the Case Management Program, or you must choose one of the alternative programs such as FHP if available.

If your written request for a change of doctor is denied, you may request an administrative review.

(If you need any help call, 533-6571 or (800) 662-9651 Toll Free.)

MAIL TO: CLIENT UTILIZATION CONTROL PROGRAM
Room 440
P.O. Box 510167
Salt Lake City, Utah 84151

ATTACHMENT 4.1

"MEMORANDUM OF AGREEMENT BETWEEN
LOCAL DISTRICT DEPARTMENT
AND DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE FINANCING

MEMORANDUM OF AGREEMENT

BETWEEN

LOCAL DISTRICT HEALTH DEPARTMENT

AND

DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

For the
Formation and Operation of a Medicaid
Case Management Program in
Rural (Non-Wasatch Front) Counties

This intra-departmental Utah Department of Health agreement is entered into between the Local District Health Department hereinafter referred to as LDHD and the Department of Health, Division of Health Care Financing, hereinafter referred to as DHCF.

I. Purpose

LDHD and DHCF agree to participate and cooperate so as to provide coordinated, appropriate and necessary care (managed health care) to eligible Medicaid clients living in specified rural counties.

To offer an alternative approach to non-managed fee for service health care delivery.

To furnish managed health care through a primary care physician serving as gatekeeper.

To implement a program that prevents over utilization, increases efficiency and educates the client on proper use of medical services.

II. Term

This agreement shall be in effect _____ 19__ through _____, 19__. Either party may terminate this agreement upon thirty (30) days written notice with or without cause. In the event of early termination, DHCF shall pay LDHD for services provided up to and including the date of termination.

III. LDHD Agrees to:

A. Contact licensed physicians within said district to explain the Medicaid case management program and enroll those primary care physicians who choose to participate in the program.

B. Contact medical support providers, including dentists, pharmacists, therapists, medical labs, etc. and explain the case management program and how it involves them.

C. Contact the medical institutions, i.e. hospitals, clinics, nursing homes, etc. and explain the case management program to each.

D. Determine there are sufficient primary care physicians, specialists and medical support providers to serve those clients who choose case management.

E. Provide ongoing training information and education to providers interested or participating in the case management program, including use of referral forms.

F. Maintain a panel of medical providers who will direct and/or provide medical care under case management for enrolled Medicaid clients.

G. Assist participating case management providers with Medicaid claim and referral form problems.

IV. DHCF Agrees to:

A. Pay LDHD per Medicaid client enrolled in the program each month for the administrative expense of operating case management in specified rural counties.

B. Provide a Health Program Representative to manage client enrollment, answer the clients questions about the program and assist the client in disenrolling from the program.

C. Make claims payment to providers enrolled in the program who provide covered services to eligible clients.

D. Collect third party liability (TPL) information on clients.

E. Manage the MMIS system and provide data such as a physician specified case management enrollment list to LDHD as appropriate.

V. It is Mutually Agreed:

A. that both parties are governmental entities under the Governmental Immunity Act, and public entities under the Indemnification of Public Officers and Employees Act, and consistent with the terms of those acts, agree to hold each other harmless for their wrongful or negligent acts or those of their employees, officers, or agents.

B. That both parties as governmental entities shall comply with and abide by provisions of Title VI of the Civil Rights Act of 1964 (42 USC 2000e) which prohibits discrimination against any employee or applicant for employment on the basis of race, religion, color or national origin; abide by Executive Order No. 11246, which prohibits discrimination on the basis of sex, and abide by the requirements of Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of handicap.

C. Exchange data on the program, client and provider which will be helpful to both parties but will not infringe on the primary rights of the client.

D. That this agreement may be modified or changed at any time by mutual written consent of both parties.

IN WITNESS WHEREOF, the parties have executed this agreement on the date appearing with their respective signatures.

DIVISION OF HEALTH CARE FINANCING	LOCAL DISTRICT HEALTH DEPARTMENT
_____	_____
Robert G. Ogden Director	Director
Date _____	Date _____

ATTACHMENT 4.2

"PREPAID HEALTH PLAN DISENROLLMENT"
(QUESTIONNAIRE FOR RECIPIENTS)

STATE OF UTAH
DEPARTMENT OF HEALTH

PROGRAM	COST CENTER	CASE NUMBER	MR ID
CASE NAME AND ADDRESS			
SOCIAL SECURITY NUMBER			

PREPAID HEALTH PLAN DISENROLLMENT

THIS FORM MUST BE RETURNED IMMEDIATELY TO:

_____ Branch Office

I want to terminate enrollment for all persons in my ADC grant currently enrolled in the

_____ and/or _____
(U-Care/FHP) (MedUcah)

I understand that cancellation of this coverage will be effective when the identification no longer appears on the AFS Medical Care Identification Card.

Date _____ Signed _____
(Head of Household)

ENROLLMENT WAS TERMINATED BECAUSE OF (Check all that apply):

U-CARE/FHP MEDUTAH

- ☐☐☐ Inconvenient location of the facilities
- ☐☐☐ Too much time between calling for an appointment and the appointment day
- ☐☐☐ Long waiting time upon arrival for scheduled appointment
- ☐☐☐ Impersonal treatment by nurses, appointment clerks, receptionists, or cashiers
- ☐☐☐ Insufficient or unclear explanation by health professional of medical problem
- ☐☐☐ Moved out of area
- ☐☐☐ Acquired other Health Insurance (e.g. Blue Cross/Blue Shield)
- ☐☐☐ Dissatisfied with quality of care given by doctors or other health professionals
- ☐☐☐ Lack of personal interest and attention given by doctors.
- ☐☐☐ Difficult getting care in an emergency
- ☐☐☐ Difficult getting to see a doctor or being taken care of without having an appointment
- ☐☐☐ Other _____

ATTACHMENT 5.1

"HMO VERIFICATION QUESTIONNAIRE"
(AND DATA)

STATE OF UTAH
DEPARTMENT OF HEALTH

NORMAN H. BANGERTER, GOVERNOR

SUZANNE DANDOY, M.D., M.P.H., EXECUTIVE DIRECTOR

HMO VERIFICATION QUESTIONNAIRE

THIS QUESTIONNAIRE WILL NOT AFFECT YOUR MEDICAID ELIGIBILITY

Name: _____

Address: _____

_____

1) Do you understand how to use your monthly State Medical Card?
   YES____NO____COMMENTS_____

2) Do you understand how to use the HMO plan you selected?
   YES____NO____COMMENTS_____

3) Which HMO did you sign up with?
   FHP_____ MedUtah_____

4) Did a representative of your selected HMO contact you?
   YES____NO____COMMENTS_____

5) Have you been told how to use the primary care physician that you selected if you joined MedUtah?
   YES____NO____COMMENTS_____

6) Have you been told how to use the Medical facilities if you joined FHP?
   YES____NO____COMMENTS_____

7) Do you understand how to get emergency care?
   YES____NO____COMMENTS_____

8) Have you been told what to do or who to see if you have a complaint?
   YES____NO____COMMENTS_____

9) Were you given a phone number and/or person to contact if you need help?
   YES____NO____COMMENTS_____

_____ _____ _____

Name (Sign) Date Phone

HMO VERIFICATION

TOTALS

1. Do you understand how to use your monthly State Medical Card?
   YES 671 NO 18

2. Do you understand how to use the HMO plan you selected?
   YES 649 NO 40

3. Which HMO did you sign up with? 689

4. Did a representative of your selected HMO contact you?
   YES 640 NO 49

5. Have you been told how to use the primary care physician that you selected?
   YES 359 NO 20

6. Have you been told how to use the Medical facilities?
   YES 301 NO 9

7. Do you understand how to get emergency care?
   YES 632 NO 57

8. Have you been told what to do or who to see if you have a complaint?
   YES 541 NO 148

9. Were you given a phone number and/or person to contact if you need help?
   YES 586 NO 103

09/08/86